INSTITUTE OF LAW RESEARCH AND REFORM

EDMONTON, ALBERTA

STERILIZATION DECISIONS: MINORS AND MENTALLY INCOMPETENT ADULTS

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INSTITUTE OF LAW RESEARCH AND REFORM

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PREFACE

and

INVITATION TO COMMENT

This is not a final report. It is a report of our tentative conclusions and proposals accompanied by draft legislation. The Institute's purpose in issuing a Report for Discussion at this time is to allow interested persons the opportunity to consider these tentative conclusions and proposals and to make their views known to the Institute. Any comments sent to the Institute will be considered when the Institute determines what recommendation, if any, it will make to the Alberta Attorney-General.

The reader's attention is drawn to the recommendations made in Chapter 9 and set out in the List of Tentative Recommendations in Part III. It would be helpful if comments would refer to these recommendations where practicable, but commentators should feel free to address any issues as they see fit.

It is just as important for interested persons to advise the Institute that they approve the proposals and the draft legislation as it is to advise the Institute that they object to them, or that they believe that they need to be revised in whole or in part. The Institute often substantially revises tentative conclusions as a result of comments it receives. Neither the proposals nor the draft legislation have the final approval of the Institute's Board of Directors. They have not been adopted, even provisionally, by the Alberta government.

Comments on this report should be in the Institute's hands by June 30, 1988. If more time is needed, please advise before May 31, 1988. Comments in writing are preferred. Oral comments may be made to the Director of the Institute or Margaret Shone of Institute Counsel.

ACKNOWLEDGEMENTS

We have had much help in forming our opinions and developing the position presented in this Report. We have not however invariably followed the advice received, and the Board of Directors of the Institute assumes sole responsibility for the form which the tentative recommendations in the Report have taken.

Professor W.F. Bowker, Director Emeritus of the Institute, first proposed the project to us. Professor Bowker provided us with an initial working paper. He has kept in touch with the project throughout and given us the benefit of his wise advice.

Margaret A. Shone of Institute Counsel had the primary responsibility for the carriage of this project and the drafting of the Report. Ms. Shone was assisted by an Advisory Committee. Professor Bowker is a member. The other members are: Mr. Bal Abbi, psychologist; Mrs. Joan Charbonneau, parent; Dr. D.C. Cumming, obstetrician; Mr. Hart Chapelle, Assistant Public Guardian (successor to Mr. Glyn Davies); Father Camille Dozois, priest; Dr. F. Harley, pediatrician; Dr. A. Donald Milliken, psychiatrist; Dr. E. Joseph Moriarty, physician; Dr. Elizabeth Savage, geneticist and lawyer; Dr. R. Sobsey, educational psychologist; and Dr. R.C. Von Borstel, geneticist. The members of the Advisory Committee have given generously of their time and expertise. Their assistance has been invaluable. We are grateful to have received it.

We also formed a sub-committee of the Board to work on the project. The sub-committee consists of J.W. Beames, Q.C. (Chairman), Professor R.G. Hammond (Director), M.B. Bielby of the Institute Board, and B.R. Burrows of Institute Counsel. These persons meet more frequently than the full Board to discuss policy, make suggestions and give direction. Ms. Bielby and Mr. Beames also attend meetings of the Advisory Committee.

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SUMMARY OF REPORT

FOR DISCUSSION

PART I

SUMMARY OF REPORT FOR DISCUSSION

STERILIZATION DECISIONS: MINORS AND MENTALLY INCOMPETENT ADULTS

A. PURPOSE OF REPORT

The present law relating to sterilization of mentally disabled persons is complex and controversial. It is complex because it is found in several different common law and statutory provisions and the exact ambit of that law is uncertain. It is controversial because the Supreme Court of Canada has recently ruled that a non-therapeutic sterilization can never safely be determined to be in the best interests of a mentally disabled person.

The Institute is of the view that it is timely and of public importance that this subject area of the law be reviewed. This consultative document sets out the evolution of the present law, its apparent parameters, the social and medical background to sterilization decisions, and tentatively recommends a new statutory regime which would better reflect the present day and foreseeable needs of Canadian citizens. Although the model evolved is intended for potential enactment by the Alberta Legislature, it could also serve, we think, as a model for other Canadian jurisdictions.

B. NEED FOR REFORM

No jurisdiction in Canada has a sterilization statute. Therefore the common law applies. Under the common law, adults who are competent to consent may choose to be sterilized for any one of several purposes, including:

- medical treatment - the sterilizing effect may be incidental to a procedure undertaken to protect the physical or mental health of the person (e.g., removal of a diseased organ);
- birth control - recent figures indicate that sterilization has replaced the pill in Canada as the leading means of contraception (of the 68.4% of Canadian women using contraceptives, 35.3% have been sterilized themselves and another 12.7% have a male partner who has been sterilized); and

- menstrual management - a hysterectomy may be performed to relieve a woman of the burden of menstruation.

Minors and adults who are not competent cannot make their own decisions. The jurisdiction of a superior court - and, consequently, the authority of a parent or guardian - at common law to make a sterilization decision for a person who is not competent is limited to therapeutic sterilization. The Supreme Court of Canada held, in the case of *Re Eve* decided in 1986, that in the exercise of this jurisdiction a non-therapeutic sterilization can *never* safely be determined to be for the benefit of a person who is not competent to consent to it. If sterilization for a non-therapeutic purpose is to be permitted, the matter is for the legislators. According to the Court, a therapeutic sterilization is one that is undertaken for the protection of physical or mental health; a non-therapeutic sterilization is one that is undertaken for a "social purpose".

As a result, unless physical or mental health is at risk, minors and adults who are not competent do not have access to sterilization for birth control and menstrual management - even for their own benefit.

In our view, legislation is needed to assist in better balancing the competing values relating to the preservation of or interference with the capacity to reproduce.

C. PRINCIPLES OF REFORM

The recommendations in the report are based on four guiding principles:

- a sterilization should be performed only where it is in the best interests of the person to be sterilized, and not where its purpose is to benefit others;
- a sterilization should be a last resort, other alternatives having been shown to be inadequate for the intended purpose;
- the "dignity, welfare and total development" of the mentally disabled person for whom the sterilization is being considered should be respected at all times; and
- the procedure for decision should ensure the protection of the other principles.

D. SUMMARY OF RECOMMENDATIONS

(1) Decision Maker

The recommendations provide for the decision to be made by a judge of the Court of Queen's Bench.

(2) Basis for Decision

The judge would be able to make an order authorizing the performance of a sterilization on a minor or adult who is not competent to consent. Before making the order, the judge would be required to satisfy himself that it would be in the best interests of the person for the sterilization to be performed.

(3) Scope of Legislation

The legislation would divide sterilization into three categories:

- sterilization for necessary medical treatment - being sterilization for the protection of the physical health of the person to be sterilized;
- elective sterilization - including sterilization for optional medical treatment and sterilization for birth control; and
- hysterectomy for menstrual management - being the removal of the uterus for the purpose of eliminating menses.

Sterilization for necessary medical treatment would be excepted from the operation of the new legislation. The existing law of consent to medical treatment would apply. Generally speaking, this would mean that the guardian of the person could consent without the need for a court order. Any delay and cost associated with bringing an application under the legislated procedure would thereby be avoided. This exception would include a sterilization to remove a diseased organ, and the sterilization of a sexually active, fertile woman with a disease (e.g., active tuberculosis, or severe heart, kidney or circulatory disease) that makes pregnancy dangerous to her physical health.

Elective sterilization and hysterectomy for menstrual management would be governed by the new legislation. A court order would be required.

Elective sterilization would include a sterilization where:

- a further pregnancy would increase the probability of serious complication with subsequent births (e.g., a series of prior births by Caesarian section);
- a congenital or hereditary disease makes it probable that pregnancy would result in a still-born child;
- a further pregnancy would jeopardize a woman's mental health (e.g., she has two children now and can't cope with the stress, or she suffered a post-partum depression after a previous birth, or agonized over the removal of a child whom she was incapable of raising);
- menstruation would produce a traumatic reaction because of a psychic fear of blood;
- offspring are not wanted;
- offspring would create an inordinate social and psychological burden;
- the financial burden associated with raising children would be intolerable; or
- the care available for the person to be sterilized would become less personal (e.g., she may have to be moved out of the home if the family or other primary caregiver would be overburdened by the supervision of social conduct and monitoring of sexual activity or caring for offspring).

Hysterectomy for menstrual management would include a hysterectomy to facilitate the integration into the community of a mentally disabled woman who cannot manage menses.

(4) Factors to Consider

Before making an order, the judge would be required to consider a number of factors specified in the legislation. Where an elective sterilization is sought, these would include: the mental condition of the person to be sterilized, her[1] physical capacity to reproduce, the likelihood that she will engage in sexual activity, the risks to her physical health with or without sterilization, the risks to her mental health, the alternatives to sterilization, the likelihood that she will marry, the risk of disability in a child that may be born, her ability to care for a child, other care available for a child, the effect of undergoing or foregoing sterilization on the care available for her, and on her opportunities for satisfying human interaction, her wishes and concerns, the wishes of her family and other caregivers, and any other relevant matter.

An elective sterilization would not be performed by hysterectomy without the authorization of a judge. That is to say, the court order would have to expressly authorize not only the sterilization but also hysterectomy as the means for performing that sterilization.

Where a hysterectomy for menstrual management is sought, the factors would include: consideration of the alternative means of menstrual management, and such other factors in the list for elective sterilization as the judge considers relevant.

(5) Procedure

An application for a sterilization order would be commenced by originating notice. The recommendations specify who may apply, who is entitled to be served with notice of the application, and who is entitled to appear and be heard on the application.

(6) Protections for Person Named in the Application

Several recommendations would serve to protect the interests of the person to be sterilized. One of these recommendations is that a judge would be required to appoint a lawyer to represent the interests of the person to be sterilized at the hearing of the application. To facilitate the making of this appointment, the originating notice would be required to include a request for the direction of a judge with respect to the appointment of a lawyer.

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[1] We use the female pronoun here and throughout the report because in practice sterilization procedures are far more likely to be performed on mentally disabled females than on mentally disabled males: *see infra* paras. 2.41-2.43.

Three more of these recommendations are intended to secure an accurate evaluation of the person to be sterilized. First, the applicant would be required to file the reports of a physician and a psychologist in support of the application. Second, the lawyer representing the person to be sterilized would be able to apply for directions for the engagement of experts to conduct evaluations. Third, a judge who is in doubt about whether an order should be made would be able to conduct his own investigation into any matter connected with the application. Where an evaluation has been conducted and report submitted, any party would be entitled to cross-examine the person making the report.

Yet another of these recommendations is that the judge would be obligated to meet personally with the person named in the application where he is of the opinion that he should do so for a purpose connected with it.

(7) General

Before making or refusing an order, the judge would have to satisfy himself that his decision would be in the best interests of the person named in the application. He would do so on the basis of the evidence put forward by the parties or the evidence obtained as a result of his own inquiry, or a combination of the two.

The costs of the application would be in the discretion of the judge and could be awarded against the Crown in Right of Alberta where it would be a hardship on the parties to pay them.

A judge would have jurisdiction to vary an order or set it aside before a sterilization is performed where circumstances have changed or new evidence has come to light.

The order would be appealable to the Court of Appeal, and would not take effect until the dismissal or discontinuance of the appeal where an appeal has been filed, or the expiration of the time allowed for appeal where no appeal has been filed. The order would be so endorsed.

Draft legislation is included in the report, as is an amendment to the Dependent Adults Act that would limit to sterilizations for necessary medical treatment the authority given to a guardian by appointment under that Act to make decisions concerning the provision of health care to a dependent adult.

PART II

REPORT FOR DISCUSSION

STERILIZATION DECISIONS: MINORS AND MENTALLY INCOMPETENT ADULTS

CHAPTER 1: INTRODUCTION TO REPORT

A. THE PROBLEM IN BRIEF

(1) Fundamental Importance of Reproduction

1.1 Reproduction is fundamental to the human race. The capacity to reproduce holds a special place in our scheme of values.

1.2 At times other values or human needs may compete or conflict with the capacity to reproduce. One example is medical treatment: the reproductive capacity may be brought to an end when a medical procedure undertaken to protect physical or mental health has the incidental, or intended, effect of sterilizing. A second example is birth control. The practice of family planning is widespread and sterilization is one of the birth control options. In recent years sterilization, chosen because it permanently prevents conception, has become the most popular method of birth control. A third example is menstrual management: in exceptional circumstances, a woman may have her uterus removed for the purpose of ending menstruation.

1.3 The purpose of this consultative report is to assist in the evolution of a legislative scheme which would better allow for the balancing of these competing values and needs.

(2) Mental Competence to Make Reproductive Decisions

1.4 Most adults are able to choose for themselves whether or not to undergo medical treatment. Most adults are also able to choose for themselves whether or not to have children, and what method of birth control, if any, including sterilization to employ to facilitate that choice. By "sterilization" we mean a surgical operation or other medical procedure or treatment that ends or is likely to end the ability to procreate. Most women are able to choose for themselves whether or not to have their uterus removed to facilitate menstrual management.

1.5 In contrast, most children and some adults are not capable of making their own decisions about sterilization for any purpose.

1.6 Some persons, by reason of minority or mental disability, lack the requisite capacity to make their own sterilization decisions. These persons are in law "mentally incompetent" to consent to sterilization. By "mentally incompetent" we mean unable to make a legally binding decision for a given purpose. By "minority" we mean being under the age of 18 years. By "mental disability" we mean having a condition (e.g. mental retardation, *dementia* or mental illness) that adversely affects mental functioning. A mentally disabled person may or may not be mentally competent to consent to sterilization. Mental incompetence is a matter for individual determination.

(3) Sterilization Decision Making for Mentally Incompetent Persons

1.7 Where a person is mentally incompetent it may be thought appropriate to permit someone else to authorize to a sterilization on that person's behalf, in carefully prescribed circumstances. Bearing this in mind, the purpose of our study has been:

1. to examine the law governing sterilization decision making for minors and mentally incompetent adults in Alberta;
2. to see how the law is applied;
3. to assess the adequacy of the law; and
4. where necessary, to make recommendations for its reform.

B. HISTORY OF PROJECT

1.8 The problem of sterilization decision making for minors and mentally incompetent adults is both current and topical, so much so that this report has gone through several transformations.

1.9 When we began our study, the law concerning the authority of a "substitute decision maker" (e.g. a parent, guardian or court) in Canada to consent to a sterilization on behalf of a minor or mentally incompetent adult was uncertain, and that uncertainty was cause for concern in many quarters.

1.10 First, members of associations committed to improving the quality of the lives of mentally disabled persons claimed that mentally disabled persons were being sterilized when sterilization was not medically necessary and should not be taking place. These persons pointed out that, because of their dependence on others, minors and mentally disabled persons (minor or adult) are in a vulnerable position and relatively powerless to protect themselves from sterilizations that are either unwanted or unwarranted; that sterilization destroys the ability to reproduce, thereby infringing a right that is basic to the human enjoyment of life; and, moreover, that physical and psychological risks attend sterilization. Although they did not uniformly object to the performance of sterilizations in appropriate circumstances, they concluded that safeguards were needed to protect the interests of minors and mentally disabled persons.

1.11 Second, physicians were concerned that a physician performing a sterilization that was not medically necessary placed himself in legal jeopardy. The concern was based on the uncertain authority of a parent or guardian to consent to the sterilization of a minor or mentally incompetent adult. Some hospital solicitors were advising hospitals not to allow the procedure because of the legal uncertainty about how to obtain proper authorization and thereby avoid risking liability.

1.12 Third, courts across Canada before whom the question was raised were taking different views of the scope of the jurisdiction exercisable by a court and the limits of the authority of parents and guardians. Legislation was non-existent or of uncertain reach. Many of the cases coming to court were being decided by superior courts in the exercise of their *parens patriae* jurisdiction, an inherent general supervisory jurisdiction derived from the monarch conferring on superior courts the responsibility to protect the interests of persons who are unable to look after themselves (i.e. "mentally incompetent"). Dramatically different results were being produced across Canada.

1.13 The situation changed on October 23, 1986. On that date, the Supreme Court of Canada delivered a unanimous judgment in which it took a narrow view of the scope of the *parens patriae* jurisdiction with respect to sterilization. The case was *Re Eve.*[2] The *parens patriae* jurisdiction was held to be limited to "therapeutic sterilizations" (i.e. sterilizations performed for "the protection of physical or mental health") and to exclude "non-therapeutic sterilizations"

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[2] (1986) 31 D.L.R. (4th) 1 (S.C.C.). Also reported as *E. (Mrs.)* v. *Eve* [1986] 2 S.C.R. 388.

(i.e. sterilizations performed for "social purposes"). The authority of parents and guardians was similarly limited: what the superior courts could not do in the exercise of their broad discretionary protective jurisdiction, parents and guardians could not do.

1.14 The problem with the law had shifted. The law is no longer uncertain. The cause for concern post-*Eve* is the narrowness of the scope of authority that exists to consent to a sterilization on behalf of a minor or mentally incompetent adult. The matter of sterilization for social purposes, said the Supreme Court, is for the legislatures.[3] However, it placed several obstacles in the way of designing legislation and we were obliged to rethink the recommendations we had drafted at that time.

1.15 To add to the drama of the subject, just over six months later, on April 30, 1987, the English House of Lords came to a contrasting conclusion on similar facts. The case was *In Re B (A Minor)*.[4] The House of Lords held that the *parens patriae* jurisdiction is not limited to therapeutic sterilizations but is to be exercised on the facts of the case in accordance with the best interests of the mentally incompetent person for whom sterilization is sought.

1.16 The House of Lords decision is not binding in Canada. However it confirmed some of our own thinking about the appropriate role of parents and guardians, and about the criteria to be considered and the standard to be applied to substitute sterilization decisions. We welcomed the decision and set about incorporating the decision into our report, where we thought the conclusions of the House of Lords are appropriate.[5]

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[3] *Id.* at 32-33.

[4] [1987] 2 All E.R. 206; 2 W.L.R. 1213 (H.L.).

[5] Several American state courts have also considered the scope of their non-statutory jurisdiction to make sterilization decisions and the viewpoints expressed in the jurisprudence building up in that country are also divergent.

CHAPTER 2: SCOPE OF REPORT

2.1 We gave a brief introduction to the problem in Chapter 1. In this chapter, we will expand on that introduction by elaborating upon the meaning of sterilization and methods by which it is achieved, exploring various reasons for performing sterilizations, and identifying the population of persons most likely to be mentally incompetent and subject to the decisions of others.

A. MEANING OF STERILIZATION

2.2 We have defined a "sterilization" as any surgical operation or other medical procedure or treatment that ends or is likely to end the ability to procreate.[6]

2.3 The main methods of sterilization in use today are tubal occlusion for females and vasectomy for males.[7] Other methods in use are hysterectomy and oophorectomy for females and castration for males, but their use is more rare.[8] All of these procedures are surgical and, for all practical purposes, irreversible. The definition of sterilization is not, however, limited to surgical sterilizations but is wide enough to encompass sterilizing techniques that may be developed in the future, for example, the injection of a drug that terminates the capacity to reproduce. It may also embrace the prescription of oral medication that has this effect. The emphasis in the definition is on bringing the reproductive capacity to a permanent end.

B. REASONS TO STERILIZE

(1) Public Interest

2.4 Sterilizations may be performed for a variety of reasons. Some of the reasons may be in the public interest. For example, a government may choose to encourage sterilization as a means of population control in an over-populated country. Or, as happened in an unproud chapter of several North American jurisdictions earlier in this century, the sterilization of mentally disabled persons could be permitted for the eugenic purpose of eliminating undesirable genetic traits and thereby improving the human gene pool for the benefit of the general population.[9]

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[6] This definition is based on the wording proposed in a bill introduced in Ontario in 1980 (hereinafter the "Ontario Bill"): *see infra* Appendix J.

[7] *See* Appendix A.

[8] *Id.*.

2.5 We do not, in this report, propose that sterilizations should be undertaken for any reason in the public interest.

(2) Interest of Individual to be Sterilized

2.6 Some of the reasons for sterilization may be in the interest of the individual to be sterilized. Three such reasons are central to this report: medical treatment, contraception and menstrual management.

(a) Medical Treatment

2.7 A sterilization may be medically indicated for the purpose of protecting a person's life or health. Here the sterilizing effect is only incidental to the medical purpose.

2.8 In this report, we refer to a sterilization undertaken for this reason as a "sterilization for medical treatment". The case law uses the term "therapeutic sterilization".

2.9 According to the Supreme Court of Canada, a therapeutic sterilization is one that is undertaken for the protection of physical or mental health.[10] A sterilization undertaken for any other purpose is a "non-therapeutic sterilization". The line between the two is somewhat imprecise.[11]

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[9] *See infra*, paras. 3.2-3.17.

[10] *Supra* n. 2 at 28-9: "I have no doubt that the [*parens patriae*] jurisdiction may be used to authorize the performance of a surgical operation that is necessary to the health of a person... And by health, I mean mental as well as physical health".

[11] The House of Lords in *Re B*, *supra* n. 4 stated (at 213 *per* Lord Hailsham, 214 *per* Lord Bridge and 219 *per* Lord Oliver) that the distinction is one of convenience and inappropriate as the basis for drawing a legal line.

2.10 A therapeutic sterilization undoubtedly includes medically necessary procedures such as the removal of a diseased organ which is threatening life or health. Here the sterilization would be performed by castration for males or hysterectomy for females.

2.11 It is probable that a therapeutic sterilization includes the sterilization of a woman with a disease (e.g. active tuberculosis, or severe heart, kidney or circulatory disease[12] that makes pregnancy dangerous to her life or physical health); and cases where frequent pregnancies increase the probability of complication with subsequent births (e.g. a series of prior births by Caesarian section).[13] It may include sterilization to avoid harm to a woman's emotional health through further pregnancies (e.g. where she has a disease of a congenital or hereditary nature that makes it probable that pregnancy would result in still-born or severely and incurably deformed children,[14] or where her mental stability is at risk). Here the intention is to produce sterility and the sterilization would be performed by tubal occlusion.[15]

2.12 A therapeutic sterilization may also include a hysterectomy to relieve a severely disabled person from a traumatic reaction produced by a psychic fear of blood.[16] It does not include hysterectomy to relieve the person from the mere burden of menstruation although this has been argued.[17]

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[12] Law Reform Commission of Canada, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24, 1979) 31 (hereinafter "LRCC WP 24").

[13] *Id.*

[14] *Id.*

[15] As the examples of harm through future pregnancies suggest, the scope attached to "therapeutic sterilization" depends on the meaning given to the words "therapy" (or "treatment") and "health" in the context of sterilization. (The therapeutic abortion provisions in the Criminal Code, R.S.C. 1970, c. C-34, s. 251 raise a similar definitional dilemma.) The definitions offered for both words are wide-ranging. Dictionary definitions of "therapeutic" commonly speak of the healing or treatment of diseases or disorders. Dictionary definitions of "health" tend to follow the definition contained in the preamble to the constitution of the World Health Organization (to which Canada became a party by ratification on August 29, 1946). In it, "health" is defined as a "state of complete physical, mental and social well-being and not merely an absence of disease or infirmity": W.H.O., *The First Ten Years of the World Health Organization* (1958) 459.

[16] This seemed to be the view of the British Columbia Court of Appeal in *Re K and Public Trustee* (1985) 19 D.L.R. (4th) 255 although the case was decided on the basis of K's "best interests".

(b) Contraception

2.13 A person who does not want to have children may choose sterilization as the preferred method of contraception. In fact, to the medical profession and members of the general public the word "sterilization" is ordinarily used to mean a freely chosen method of birth control. Where a procedure is used for medical treatment, the practice is to refer to the diagnostic problem or name the medical procedure to be performed.

2.14 In this report we refer to a sterilization that is undertaken for the sole or primary purpose of ending the ability to procreate as a "sterilization for contraception".[18] The sterilization is intended simply to put an end to the person's reproductive capacity.[19] The procedure is used for its socio-economic rather than its medical consequences.[30] In the language of the case law it would be a "non-therapeutic sterilization".

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[17] Prior to the *Eve* decision there was some difference of opinion about whether the performance of a hysterectomy on a mentally incompetent woman for the purpose of menstrual management could be therapeutic. Some physicians took the view that it constituted therapy. Associations for the mentally retarded generally took the view that it did not. The Canada Law Reform Commission expressed doubt that it is therapy: *supra* n. 9 at 34. Bernard M. Dickens, a noted Canadian scholar on health and reproduction law, wrote that "hygienic reasons are classified as non-therapeutic lest retarded girls be sterilized upon mere grounds of institutional inconvenience in managing their menstruation": "Reproduction Law and Medical Consent" (1985) 35 *U.T. L.J.* 255 at 270. Susan C. Hayes and Robert Hayes make a strong statement in the Australian text, ***Mental Retardation: Law, Policy and Administration*** (1982) at 80:

> Hygienic 'reasons' for sterilization appear to reflect the medical profession's inadequate knowledge or training in social and self-help skills for retarded people, as well as a general coyness about menstruation. No reasonable medical practitioner would undertake an operation for colostomy because the patient smeared faeces around the house - why is the smearing of menstrual blood considered so much more abhorrent and untreatable by education, conditioning and behaviour modification techniques? The application of the principle of the least restrictive alternative seems tragically ignored in the area of sterilization.

[18] "Contraception" may be defined as the prevention of fertilization of the ovum (the female egg). It includes natural family planning methods such as rhythmic abstention and drugs (e.g. "the pill") which prevent conception from occurring. "Birth control", which is wider, includes methods that inhibit implantation after fertilization and it includes abortion. *See* Appendix D.

[19] Sterilization for the purpose of contraception was frowned on by society until recently and is still not condoned by the Catholic Church.

2.15 Family planning is in this category. For example, a couple may decide that they would not be able to give offspring proper parental care. They might base their decision on an assessment of their personalities or on the presence of countervailing life circumstances, such as the inability to meet the financial demands of bearing and raising children. They may wish to prevent the birth of a child where the risk of deformity is high, both in the interests of the as yet unconceived child and because they are themselves unwilling to assume the burden of caring for a disabled child. The sterilization would be performed by vasectomy for males, or tubal occlusion for females.

(c) Menstrual Management

2.16 Another reason for sterilization in the private interest is to relieve a woman of the burden of menstrual management and thereby facilitate personal hygiene. The sterilization would be performed by hysterectomy to remove the uterus. We refer to a sterilization undertaken for this purpose as an "hysterectomy for menstrual management". It is another example of a "non-therapeutic sterilization".

2.17 Hysterectomy for menstrual management is in a different class from other non-therapeutic sterilization and that is why we deal with it separately. First, hysterectomy is major surgery and, unlike the less intrusive procedures available to achieve contraception, it is usually reserved for use as medical treatment. Second, hysterectomy is performed only on females. Third, competent women rarely, if ever, request them for menstrual management.

(3) Interest of Other Persons

2.18 In the case of a mentally incompetent person, the personal interests of the individual to be sterilized may provide the sole basis for a sterilization decision. Alternatively, a sterilization may be undertaken because it is of direct benefit to the persons responsible for the care of the person being sterilized (e.g. because it would relieve them of concerns about pregnancy or the burden of menstrual management) or to future progeny (because it would protect them from being born to a person who is incapable of being an adequate parent). In these cases, the reasons for sterilization fall mid-way between the public interest and the interests of the person to be sterilized. They are "semi-public" in nature.

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[30] M.W. Burns, "*Wyatt* v. *Aderholt*: Constitutional Standards for Statutory and Consensual Sterilization in State Mental Institutions" (1975) 1 *L. and Psych. Rev.* 79, n. 7 citing *Roe* v. *Wade*, 410 U.S. 113 (1973) (discretionary abortion); Annotation, 35 A.L.R. 3d 693 (1971) (inter-vivos organ donation); *Hathaway* v. *Worchester City Hospital*, 475 F. 2d 701 at 702 (discretionary sterilization).

2.19 In our report, we raise questions about the propriety of considering the semi-public interests of caregivers and future progeny in relation to sterilization for contraception or hysterectomy for menstrual management. We conclude that there is too much risk of confusing the interests of others with the interests of the mentally incompetent person and recommend against employing these semi-public interests as criteria for authorizing sterilization. However, that is not to say that these interests are not indirectly reflected in other criteria which we do recommend be accepted (e.g., the value of home care compared with institutional care).

C. THE POPULATION AFFECTED

(1) Sources of Mental Incompetence

2.20 The title of our report names minors and mentally incompetent adults. Persons in both categories share certain traits in common. Both are unable to look after themselves fully or make legally binding decisions in respect of various matters, and both are regarded in law as needing protection.[21]

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[21] The concept of mental competence is an elusive one. It does not describe a legal status but has to do, instead, with a person's capacity to perform a specific legal function at a given time. A person may be competent to marry but incompetent to make a will: *In the Estate of Park* [1953] 2 All E.R. 1411 (C.A.); *Re McElroy* (1978) 93 D.L.R. (3d) 522 (Ont. Surr. Ct.). A person may be competent to manage his estate, but incompetent to make a decision about his mental health treatment: *Institute Philippe Pinel de Montreal* v. *Dion* (1983) 2 D.L.R. (4th) 234 (C.S.) at 439.

There is no single or even widely-accepted definition of mental competence. *See* the possibilities identified in the United States by P.S. Appelbaum, "Informed consent" (1985) 1 *Law and Mental Health: International Perspectives* 45 and L.H. Roth et al., "Tests of competency to consent for treatment" (1977) 134 *Am. J. of Psych.* 279. Often it is defined in terms of the person's ability to understand and appreciate the nature of the subject matter at hand and the consequences of the decision.

There is no simple diagnostic test available. The ability to do more than

(a) Minority

2.21 Children are born helpless. They spend their childhood acquiring the attributes that will enable them to assume the rights and responsibilities enjoyed by adults.

2.22 Ordinarily the "mental incompetence" of children is a function of immature age and not of mental disability. Most minors, in the course of development, will mature to competence. On the attainment of maturity, they will be able to make their own decisions as fully functioning adults.

2.23 Because their dependence renders them vulnerable to the exercise of authority by others, normally developing minors may need protection to ensure that the authority over them is not abused and that, in the absence of compelling circumstances otherwise, their power of procreation is preserved. To the extent that such protection is needed, our report includes persons who are mentally incompetent by reason of minority.

(b) Mental Disability

2.24 Childhood is not the only source of mental incompetence. Some persons are born with defects that limit their potential for intellectual, social and psychological development. Other persons experience injury or disease that impairs past development and limits future potential for

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[21](cont'd) evidence a choice is probably not enough, but actual understanding is not required.

No amount of information will render an incompetent person competent.

Many questions about the attributes of mental competence remain unanswered in law. Is mental competence a strictly intellectual measure? Does it encompass psychosocial impairment or adaptive behaviour disabilities? Must the decision itself be reasonable in the sense of being roughly congruent with what a reasonable person would decide? Must it be reached in a rational manner: i.e. by the rational manipulation of the information provided? What does the word "appreciate" add? Does it extend to subjective factors that are peculiar to this person and his situation? Does it introduce affective elements into the decision making process? Is the ability to resist expectable levels of coercion included? Must the person indicate his willingness and apparent "reliability" to assume responsibility? Is the scale a sliding one to be adjusted in accordance with the likely harm to the person if an incompetent decision is reached?

A point to note is that the higher the level of competence required the more frequent will be the need for substitute decision making and therefore the higher the incidence of interference with the personal autonomy of individuals in society.

development. These persons, minor or adult, who are afflicted with a mental disability of a continuing nature are the ones with whom our report is primarily concerned.

(i) Mental Retardation

2.25 One mentally disabling condition is mental retardation, signified during childhood by low score on intelligence tests.[22] Classification as mentally retarded or as mentally disabled does not automatically render a person mentally incompetent. Mental incompetence is a question of fact to be determined in each particular case. The finding relates to the ability of a given individual to understand in the specific purpose at hand.[23] A high incidence of mental incompetence may nevertheless be expected to be found among mentally retarded persons. That is to say, although the mentally retarded are not the only population about which this report is concerned, they are the major population.

2.26 Mentally retarded persons comprise about 3% of the general population.[24] There are approximately 70,623 mentally retarded persons of all ages in Alberta at the present time.[25]

2.27 It is common today for mental retardation to be assessed and classified on the basis of I.Q. test scores in combination with "adaptive behaviour" or "functional level" tests. The classification system developed by the American Association of Mental Deficiency[26] is widely used. It divides retardation into four levels: mild, moderate, severe and profound.

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[22] *See* Appendix B.

[23] *See supra* n. 21.

[24] American Association on Mental Deficiency, *Classification in Mental Retardation* (H. Grossman ed. 1983) 76. The figure, which is based on IQ alone, has been corroborated in the United States by a number of epidemiological studies. It is the figure used by the Alberta Association for Community Living (formerly the Alberta Association for the Mentally Retarded).

[25] Based on a total Alberta population figure of 2,354,100 estimated as of October 1, 1985: Alberta Bureau of Statistics, *Alberta Quarterly Population Growth*, Table 2.

[26] *Supra* n. 24. The system is consistent with other major classification systems in current use: the World Health Organization's International Classification of Diseases-9 (ICD-9) and the American Psychiatric Association's Diagnostic and Statistical Manual-III (DSM-III) (which is widely used by psychiatrists in Canada).

2.28 It is widely accepted that the majority of mentally retarded persons are in the mildly retarded classification. These are persons with I.Q.'s of from 50-55 to approximately 70 and who, at the age of 15 years or older, function as children aged 9 to 12 years. They comprise between 75% and 80% of the mentally retarded population.

2.29 Moderately retarded persons have I.Q.'s falling in the 35-40 to 50-55 range. A moderately retarded person 15 years of age or older would be functioning as a child aged 6 to 9 years. Moderately retarded persons comprise from 15% to 20% of the mentally retarded population.

2.30 Severely mentally retarded persons have I.Q.'s of from 20-25 to 35-40 and when 15 years of age or older function as children aged 3 to 6 years. Profoundly mentally retarded persons have an I.Q. below 20 or 25 and when 15 years of age or older function as children below the age of 3. These two categories together comprise the remaining 5% of the mentally retarded population.

2.31 Among the mentally retarded, it is likely that all persons classified as severely or profoundly mentally retarded will be permanently mentally incompetent to make a personal decision about sterilization for any purpose; a substantial number of those classified as moderately mentally retarded and a small number of those classified as mildly mentally retarded will be permanently mentally incompetent to make such a decision.

(ii) Dementia

2.32 Another mentally disabling condition is *Dementia*. It is similar to mental retardation but is the reduction of intellectual functioning due to the occurrence of disease or injury. "The diagnosis of Dementia may be made at any time after the intellectual quotient is fairly stable (usually by age 3 or 4)."[27] Dementia usually occurs among the elderly and is most commonly of the Alzheimer type. Other causes include central nervous system infections, brain trauma, vascular disease and neurological diseases.[28]

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[27] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (1980) 109.

[28] *Id.* at 110.

(iii) Mental Illness

2.33 A third mentally disabling condition is mental illness. It is not easily defined, but embraces the areas of mental dysfunction described in the following definition of mental illness as:[29]

> a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

The definition goes on specifically to exclude mental retardation.

2.34 The major categories of mental illness are depression (a mood disorder), a variant bi-polar illness (manic-depression) and schizophrenia (a thought disorder). There are wide variations in symptomatology and severity. The occurrence of mental illness is independent of intelligence.

2.35 Although the causes of mental illness are largely unknown, evidence that points to the influence of biology is mounting. Chromosomal markers have recently been identified for depression and schizophrenia. Viral theories of schizophrenia are under investigation. Mere dissatisfaction with one's lot in life is not enough. More is involved than normal reactions to daily stress or major life crises such as marriage breakdown or the death of a close family member.

2.36 Unlike mental retardation and *dementia*, the effects of mental illness are usually shortlasted. Some illnesses remit naturally. Others are responsive to treatment:[30]

> Many mental illnesses are manageable with medications (chemotherapy) which have become increasingly specific and refined over the years. Others respond to verbal explorations (psychotherapy), punishment and reward systems of training (behavioural modification) and a host of other treatment techniques which may be used singly or in concert with endless variations for individual effectiveness. Professionals and other persons provide a wide range of specialized services as they participate in the care and treatment of the mentally ill through community services and hospitalization.

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[29] Vermont Statutes Annotated, T.18, s. 7101(14). This definition, with some modification, has been recommended for use in mental health legislation in Alberta by the Task Force to Review the Mental Health Act (1983, Richard B. Drewry, chairman) (hereinafter the "Drewry Report") and in Canada by the Uniform Law Conference of Canada in the Uniform Mental Health Act adopted August 11, 1987.

[30] Drewry Report, *id.* at 41.

Even in cases of lengthy or chronic illness, the acute states are often episodic and the mental incompetence transitory such that a person suffering from an extended mental illness may be rational most of the time.

2.37 Mental illness has a surprisingly high rate of incidence. A joint publication of Statistics Canada and the Canadian Mental Health Association reveals:[31]

- It has been estimated that one of every eight Canadians can expect to be hospitalized for a mental illness at least once during his or her lifetime.
- Suicide was the second most frequent cause of death among Canadians between the ages of 15 and 39.
- Mental illness was the second leading category in general hospital use among those aged 10 - 44, exceeded only by accidents among men and pregnancy among women.
- Between 10% and 30% of the population have some form of mental illness, depending on the perceptions and definitions of the various disorders in this group.
- Compulsory hospitalization under legislative acts accounted for more than one-third of admissions to mental hospitals.

2.38 Because of its more transitory nature and the ever present and very real chance of scientific breakthrough, mental incompetence due to mental illness is less likely than mental incompetence due to mental retardation or *dementia* to provide the basis for sterilization decision making by another.

(2) Duration of the Condition

2.39 The duration of the condition of mental incompetence is relevant to sterilization decision making for mentally incompetent persons. Except where physical or mental health is at serious risk, it may be preferable to postpone a sterilization until the person to be sterilized acquires competence to decide (in the case of a minor) or regains it (in a case where the mental disability is temporary).

2.40 Our recommendations require the duration of the condition of mental incompetence to be taken into account.

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[31] Statistics Canada, *One of Eight: Mental Illness in Canada* (1981). These estimates are based on statistics compiled for the year 1978.

(3) Pronoun Gender: Issue Predominantly Female

2.41 The choice of pronoun gender for use in this report has been a problem. The available statistics indicate that sterilization procedures are more commonly performed on women than men.[32] We believe this to be particularly true for mentally disabled persons. As has been pointed out elsewhere:[33]

> The majority, by far, of the reported cases brought to court in the United States, Canada and England involve the issue of the authority to sterilize a mentally incompetent female. Cases involving the sterilization of a mentally incompetent male are extremely rare. This is not particularly surprising given that it is females who face the risks of pregnancy and delivery, miscarriage, or abortion; it is females who thereafter, either themselves or with the assistance of their caregivers, bear the brunt of the burden of child care; and it is females who are apt to suffer the psychological consequences of separation if the child is removed.

2.42 It is a safe assumption that in the majority of cases sterilization procedures performed on persons in the group aged 19 years or under are performed for non-therapeutic, or "social" reasons, the medical reasons for sterilizing persons in this age group being minimal. In 1986, 63 sterilizations were performed on females in this age group in Alberta (46 by tubal occlusion, 17 by hysterectomy) whereas no vasectomies were performed on males.[34] In the preceding year, 56 sterilizations were performed on females (42 by tubal occlusion, 14 by hysterectomy) whereas 1 vasectomy was performed on a male.[35]

2.43 We considered staying with established pronoun usage, with the use of masculine pronouns including the feminine, despite the distorting effect on the actual incidence of sterilization. We also considered using combined pronoun references ("he or she", "him or her") but rejected this choice in the interests of brevity. In the end, we decided to use feminine pronouns in the text of the report to reflect the much higher incidence of sterilization of women. The accompanying draft Act uses combined pronoun references. This is in accordance with the drafting convention adopted by the Drafting Section of the Uniform Law Conference in 1986.

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[32] *See* Appendix E.

[33] Margaret A. Shone, "Mental Health - Sterilization of Mentally Retarded Persons - *Parens Patriae* Power: *Re Eve*", (1987) 66 *Can. Bar Rev.* 635, n. 4.

[34] *See* Appendix E.

[35] *Id.*

CHAPTER 3: THE SOCIAL HISTORY

3.1 In the past two decades, decision making about the sterilization of mentally incompetent persons for reasons other than medical treatment has emerged as an issue of public concern. The issue has attracted litigation in several of the United States, in Canada and England. The concern is attributable to a complex of interrelated social and scientific developments. The law governing sterilization cannot be properly considered without first locating the issue in the contemporary picture of social and scientific developments. This we do in this chapter.

A. PAST PRACTICES

3.2 For the greater part of the present century, the practice has been to care for mentally disabled persons in institutions. The institutional care ordinarily commenced at an early age and often continued for a lifetime. Institutional measures, such as close supervision and the segregation of males and females, were imposed to prevent any opportunity for sexual encounters. Sterilization was sometimes performed for reasons of institutional convenience.

3.3 During this period, which spanned from the turn of the century to the late 1960's, eugenic theory held sway among many members of the scientific community. "Eugenics" is defined as "the science which deals with the influences, especially prenatal influences, that tend to better the innate qualities of man and to develop them to the highest degree".[36] Sterilization for a eugenic purpose is intended to prevent the transmission of a person's undesirable traits to his progeny through biological inheritance. A program of eugenic sterilization is intended to reduce or eliminate the incidence of undesirable traits in the population for the benefit of society.

3.4 The eugenists argued that mental illness, mental retardation, epilepsy, alcoholism, pauperism, certain forms of criminality and various social defects (included were prostitution, sexual perversion and other forms of moral degeneracy) were genetically determined and inherited. They also believed that persons with these diseases or conditions had a higher reproductive rate than the normal population and that the gene pool in the general population was therefore being weakened. They attributed less importance to the role of the environment.[37]

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[36] *Stedman's Medical Legal Dictionary: Third Unabridged Lawyers' Edition* (1974) 438.

3.5 The evolution of these beliefs coincided with the development of surgical techniques (salpingectomy for females and vasectomy for males) for the prevention of procreation.[38]

3.6 Led by Indiana in 1907,[39] many North American jurisdictions including Alberta[40] in 1928 and British Columbia[41] in 1933 enacted legislation to permit the sterilization of mentally disabled persons (seen as genetically deficient) on eugenic grounds.[42]

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[37] LRCC WP 24, *supra* n. 12 at 24-7.

[38] *Id.* at 24. Tubal occlusion techniques are described in Appendix A. Salpingectomy involves the removal of the entire fallopian tube and requires a major incision. Albertans who worked in institutions remember instances of castration being used as the method of sterilization for males.

[39] *Id.* at 26; Monroe E. Price and Robert A. Burt, "Sterilization, State Action, and the Concept of Consent in The Law and the Mentally Retarded" (1975) *L. and Psych. Rev.* 57 at 61. A Bill authorizing eugenic sterilization operations was defeated in the Michigan legislature in 1897: *supra* n. 12 at 26. A Bill was passed by the Legislature in Pennsylvania in 1905 but vetoed by the governor: Price and Burt at 61. The trend spread so rapidly that by 1917, fifteen states had adopted eugenic sterilization laws and by 1937, thirty-one had done so: *id.* at 26. The United States Supreme Court upheld the constitutional validity of one of these statutes in the 1927 case of *Buck* v. *Bell*, 274 U.S. 200. The judgment of Mr. Justice Holmes contains these famous words:

> It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes... Three generations of imbeciles are enough.

A recent commentator has concluded that the Bucks were the unfortunate victims of an elaborate legislative and judicial campaign to ensure the legally sanctioned success of a eugenic sterilization program: Paul A. Lombardo, "Three Generations, No Imbeciles: New Light on *Buck* v. *Bell*" (1985) 60 *N.Y.U.L.R.* 31 at 32 and 61. Dr. Lombardo and others have pointed out that Carrie Buck, her mother, Emma, and her daughter, Vivian, were not "imbeciles" as Justice Holmes had described them. Emma and Carrie were alleged in the proceedings to have mental ages of nearly 8 and 9 years respectively, which would place them at higher levels of feeblemindedness on the Binet-Simon intelligence test in use at the time. Vivian performed quite well as a student and at one point made the "Honour Roll" during the two years of schooling that preceded her premature death from an infectious disease at the age of 8.

[40] Sexual Sterilization Act, S.A. 1928, c. 37.

[41] Sexual Sterilization Act, S.B.C. 1933, c. 59.

[42] The enactment of legislation in Alberta and British Columbia was undoubtedly influenced by the 1927 holding of the United States Supreme Court in *Buck* v. *Bell*,

3.7 The eugenics theory has since been discredited and eugenic sterilization laws have fallen into general disfavour. There are several reasons why.

3.8 First, eugenic sterilization laws were founded on scientifically unsound assumptions about the transmission of genetic characteristics[43] and sterilization was authorized for reasons that have since turned out to have been scientifically unsound.

3.9 Second, the societal interest in the production of fine offspring is no longer viewed as great enough to justify infringing the principle of the inviolability of the person (not, at least, in the absence of strict procedural safeguards to protect the interests of the individual to be sterilized). This principle embraces the notion of freedom from bodily interference or intrusion by others.

3.10 Third, viewed from a civil libertarian perspective, such laws unjustifiably interfere with the right to make personal decisions about procreation. Under eugenic sterilization laws, the sterilization could be performed on the authority of someone else irrespective of the mental competence of the person being sterilized, actual or potential, to consent personally to sterilization. Her ability to do so, in some cases at least, was irrelevant.[44] This is because the sterilization was imposed, as a matter of government policy, solely to eliminate undesirable hereditary traits in society by removing the reproductive capacity of persons carrying those traits. It was not performed out of consideration for the interests of the individual being sterilized.

3.11 The widespread public revulsion against involuntary sterilization arising from the cruel and inhuman "experiments" in sterilizations performed by Nazi doctors during World War II reinforced the second and third reasons.[45]

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[42](cont'd) *supra* n. 39. The history of the Alberta legislation is described briefly in Appendix C.

[43] *See e.g.* K. McWhirter and J. Weijer, "The Alberta Sterilization Act: A Genetic Critique" (1969) 19 *U.T.L.J.* 424.

[44] *See e.g.* the 1937 and 1942 amendments to the Alberta Sexual Sterilization Act: S.A. 1937, c. 47; S.A. 1942, c. 48, s. 3. They are described in Appendix C.

[45] *See* Glanville Williams, *The Sanctity of Life and the Criminal Law* (1957).

3.12 Fourth, persons who have since proven themselves capable of living in the community and of caring for other people's children were sterilized under eugenic sterilization laws as a condition of release from an institution.[46]

3.13 Fifth, deceptions were carried out. A female might be told, for example, that the operation was an appendectomy.[47]

3.14 Sixth, the legislation did not apply equally to all members of society. It applied instead to persons with characteristics which the legislators regarded as undesirable, thereby reflecting legislated biases toward certain medical syndromes.[48]

3.15 Seventh, evidence suggests that in practice disproportionately frequent use was made of the legislation to authorize the sterilization of females rather than males, children rather than adults, unemployed persons and domestics rather than professionals, institutionalized persons rather than uninstitutionalized persons, persons of Roman and Greek Catholic religious affiliations, and persons of East European ancestry and Indian and Metis ethnicity rather than of British and West European ancestry.[49]

3.16 The Alberta Act was repealed in 1972;[50] the British Columbia Act in 1973.[51] Eugenic sterilization is a shameful blot on our past. The sense of abhorrent reaction to past sterilization abuses perpetrated in furtherance of eugenic theory leaves the issue of sterilization especially sensitive and difficult to look at with rational objectivity today. We do not propose the return of eugenic interventions, but mention the purpose here for reasons of history and the completeness of our discussion.

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[46] G. Sabagh and R.B. Edgerton, "Sterilized Mental Defectives Look at Eugenic Sterilization" (1962) 9 *Eugenics Quarterly* 231-22.

[47] *Stump* v. *Sparkman*, 435 U.S. 349 (1978).

[48] *Supra* n. 43 at 431.

[49] Tim Christian, "The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act" (1974), unpublished paper cited in LRCC WP 24, *supra* n. 12 at 42-45.

[50] S.A. 1972, c. 87. During the 44 years the Alberta Act was in force, some 2,500 persons were sterilized pursuant to its terms.

[51] S.B.C. 1973, c. 79.

3.17 The decline of the eugenics theory is one development that has given rise to sterilization decision making as a problem today. The repeal of the eugenic sterilization legislation led some persons to perceive a need for an alternative authority to sterilize.

B. INTERVENING TRENDS

(1) The "Normalization" Concept

3.18 A second development, concurrent in time with the fall into disrepute of eugenic sterilization, was the promotion of the goal of "normalization" for mentally disabled persons. Professor Nirje, writing in 1970, defined the concept as "making available to the mentally subnormal patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society".[52] The normalization concept emphasizes the similarities, rather than the differences, between mentally disabled persons and other persons.

3.19 Beginning in the mid-1970's, the acceptance of the goal of normalization led to large scale reductions in institutional beds ("deinstitutionalization") and the movement of large numbers of mentally retarded and mentally ill persons into the community ("communitization"). With the entry of mentally disabled persons into the community there was a significant shift in the responsibility for the care and supervision of mentally disabled persons from institutional caregivers to family (usually parents) or other private caregivers. Supervision was more difficult, the opportunities for sexual encounters increased, and concern to prevent conception and, in particular, pregnancy in mentally incompetent females escalated.[53]

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[52] B. Nirje, "Symposium on 'Normalization': The Normalization Principle - Implications and Comments" (1970) 16 *Brit. J. Mental Subnormality* 62. *See also*: B. Nirje, "The Normalization Principle and its Human Management Implications" in *Changing Patterns in Residential Services for the Mentally Retarded* (R. Kugel and W. Wolfensberger eds. 1969) 81; Wolfensberger, "The Principle of Normalization and Its Implication to Psychiatric Services" (1970) 127 *Am. J. Psychiatry* 291 at 291-7; and R.A. McCormick, *Health and Medicine in the Catholic Tradition* (1984). In discussing the principles of integration, normalization and personalization for the retarded espoused in the "Document of the Holy See for the International Year of the Disabled Persons" published in conjunction with the United Nations proclamation of 1981 as the International Year of Disabled Persons, R.A. McCormick states (at 149):

> The principle of integration 'opposes the tendency to isolate, segregate, and neglect the disabled'. It includes more positively a commitment to make the disabled person 'a subject in the fullest sense'. The principle of normalization involves an effort to ensure the complete rehabilitation of the disabled person by providing an environment as close as possible to the normal. The principle of personalization emphasizes the fact that in the various forms of treatment, it is always the dignity, welfare, and total development of the handicapped person, in all his or her dimensions and physical, moral, and spiritual faculties that must be primarily considered, protected and promoted.

3.20 The movement of mentally disabled persons into the community has therefore contributed to the upsurge in litigation on sterilization in the United States, Canada and England. We note this as a third development.

(2) Medical Advances to Prolong Life

3.21 Medical advances have prolonged the life expectancies of mentally disabled persons, thereby lengthening the period of fertility and increasing the perceived need for protection against conception.[54] This is a fourth development that has contributed to the current dilemma about sterilization decision making.

(3) Relaxation of Birth Control Restrictions

3.22 During the time that reservations about the eugenic sterilization of mentally incompetent persons were growing and that deinstitutionalization was taking place, a fifth development was occurring. The use of "unnatural" methods of birth control was fast gaining acceptance in the general population.

3.23 A mere two decades ago, Canadian society frowned on the use of unnatural methods of birth control.[55] Until 1969, it was a criminal offence against morality in Canada to advertise contraceptive drugs or devices for public sale or use.[56]

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[53] A. Munro, "The Sterilization Rights of Mental Retardates" (1982) 39 *Wash. & Lee L. Rev.* 207 at 211, n. 22.

[54] *Id.*

[55] This was a result of the influence of Christian teachings: Robert P. Kouri, "The Legality of Purely Contraceptive Sterilization" (1976) 7 *Rev. de droit de l'U. de Sherbrook* 1 at 2. The Roman Catholic Church still opposes interference except by periodic abstention from intercourse.

[56] The prohibition was removed from s-s. 150(2)(c) of the Criminal Code (now R.S.C. 1970, c. C-34, s-s. 159(2)(c)) and made a matter for regulation under the Food and Drugs Act (now R.S.C. 1970, c. F-27, s-s. 3(3)) by S.C. 1968-69,

3.24 In recent years, due largely to the relaxation of these restrictions and the advent of "the pill", public attitudes have changed greatly and birth control by "unnatural" methods is practised widely.[57] As a consequence, the right to use the method of birth control of choice now appears to be widely accepted.

3.25 The success rate of "the pill" as a contraceptive reduced the risk that sexual intercourse would result in pregnancy. The acceptance of the use of unnatural methods of birth control therefore led, in turn, to greater tolerance of sexual activity in the general population, both within and outside marriage.[58] The change in attitude coupled with the normalization concept contributed to greater acceptance of the more open expression of sexuality by mentally disabled persons as well.

3.26 But sexual expression is one thing. Bearing responsibility for the children conceived and born in consequence of that expression is another. The notion of normalization meant that the birth control protections available to members of the general population should also be available for use by mentally disabled persons; however birth control management can be deceptively difficult for mentally disabled persons. Some caregivers wanted to protect mentally disabled persons from the trauma of an unwanted or unplanned birth; others wanted to protect themselves from the burden of caring for the child that may be born; still others wanted to prevent the conception and birth of a child whose life was destined to be difficult. This was a sixth development.

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[56](cont'd) c. 41, s. 13. The amendment took effect on 1 January 1970.

[57] According to a 1984 Canadian Fertility Study conducted by Karol Krotki, 68.4% of Canadian women aged 18 to 49 use some form of contraception: John Geiger, "Canadians dying out, study says" (February 19, 1986) *The Edmonton Journal* B-1. Birth control methods other than sterilization are described in Appendix D.

[58] With the appearance of AIDS, this era of relatively free sexual mores may be passing.

(4) The Popularity of Sterilization as a Method of Birth Control

3.27 A seventh development has been the growth in popularity of sterilization.[59] As the practice of unnatural means of birth control gained acceptance in the general population, the prevalence of sterilization as the chosen means of birth control increased. Improved sterilization techniques contributed to the growth in popularity of this choice. (The usual sterilization operations for both males and females have been refined from the cruder surgery of earlier years to the safe, simple minor surgery in use today.)[60] As well, sterilization is preferred by many persons because of its comparative reliability to control fertility.

3.28 In Canada, sterilization has replaced the pill as the leading means of contraception. According to a 1984 Canadian Fertility Study, of the 68.4% of Canadian women aged 18 to 49 who are using contraceptives, 48% are using sterilization: 35.3% having been sterilized themselves and another 12.7% having a male partner who has been sterilized.[61]

3.29 It has been estimated that by 1982 approximately 110 million individuals worldwide (28 million in the developed world and 82 million in the developing world) would have undergone sterilization for the purpose of contraception, with surgical sterilization being the contraceptive method chosen by 33% of estimated contraceptive users. Oral contraceptives would have been the choice of 16% of estimated contraceptive users; IUD's, 18%; and condoms, 12%.[62]

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[59] In 1954, Lord Denning, then a Justice of the English Court of Appeal, asserted that sterilization for the purpose of contraception is "injurious to the public interest", "degrading to the man himself", "injurious to his wife and to any woman whom he may marry" and "opens [the way] to licentiousness": *Bravery* v. *Bravery* [1954] 3 All E.R. 59. Although his statement is oft-quoted, Lord Denning's view did not prevail. Indeed, the majority of judges comprising the Court expressly dissociated themselves from these remarks.

[60] Appendix A.

[61] *Supra* n. 57. *See also* "Sterilization is first choice" (January 8, 1986) *The Edmonton Journal* A-2. Compare the use of the pill by 28%, condom by 9.1%, IUD by 8.3% and all other methods including diaphragm, foam, rhythm method and withdrawal by 6.6%. Other figures for 1984 indicate that 41.5% of married women of reproductive age in Canada are protected from pregnancy by sterilization. 28.3% have been sterilized themselves and 13.2% have a male partner who has been sterilized: John A. Ross et al., "Worldwide Trends in Voluntary Sterilization" (1986) 12 *Int. Fam. Planning Perspectives* 34 at 35.

[62] J. Shelton and J. Spiedel, "The Need for Non-surgical Sterilization" in *Female Transcervical Sterilization* (G. Zatuchni et al., eds. 1983) 1. Moreover, evidence suggests that the development of truly reversible contraceptive procedures would

(5) Sterilization as a Birth Control Option for Mentally Disabled Persons

3.30 Because sterilization is available as a birth control option for persons in the general population, resort to it for mentally disabled persons would be consistent with "normalization" theory. Caregivers faced with the difficulties of managing alternative methods have looked to sterilization as the most viable method of birth control. That is to say, there is a present demand in some quarters for a legal source of authority to perform sterilization for contraception on mentally incompetent persons.[63] This is an eighth development.

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[62] (cont'd) enhance the acceptability of contraceptive procedures even further: R.N. Shain, "The Potential Impact of Reversibility on Selection of Tubal Sterilization" (1980) 22 *Contraception* 227.

In the United States by 1980, sterilization had become the leading contraceptive method among currently married women 30 to 44 years of age and the second most common method for women aged 15 to 44 years: T.F. Nolan et al., "Cumulative Prevalence Rates and Corrected Incidence Rates of Surgical Sterilization Among Women in the United States, 1971-1978" (1982) 116 *Am. J. Epidemiol.* 776. In absolute numbers, close to 7 million individuals (females comprising 58% and males 42%) in the United States are believed to have been sterilized between 1975 and 1980: Association for Voluntary Sterilization, *Revised Estimates of the Number of Sterilizations Performed in the United States through 1982* (1983). In the 11 year period between 1970 and 1980, approximately 942,000 women aged 15 to 24 underwent tubal occlusions and sterilization rates rose steadily from 3 per 1000 to 11 per 1000 for women in the 20 to 24 year age group. The rate remained stable at less than 1 per 1000 for women in the 15 to 19 year age group. The rates increased for both currently married and previously married women but remained low for never-married women. Most tubal sterilizations were performed after a delivery or abortion: N.C. Lee et al., "Tubal Sterilization in Women 15 - 24 Years of Age" (1984) 74 *Am. J. Pub. Health* 1363.

The age of women at sterilization is also decreasing in the United States: Nolan et al.; N. Marcil-Gratton and E. Lapierre-Adamcyk "Sterilization in Quebec" (1983) 15 *Family Plann. Perspective* 73. Nolan reported that the cumulative prevalence of tubal occlusions among U.S. women more than doubled between 1971 and 1978 for women aged 15 to 44 years. Among women under 30 years of age, the prevalence more than tripled. By 1978, 8% of all women aged 35 to 39 had undergone tubal sterilization.

The increases in prevalence of hysterectomy between 1971 and 1978 were less marked than for tubal sterilization. Overall numbers of hysterectomy increased by only 2%. In 1978, 19% of women age 40 to 44 had undergone hysterectomy.

The greatest increases in the prevalence of surgical sterilization were among younger women. Six times as many 20 to 24 year old women were sterilized in 1978 as in 1971. However, the greatest increase in absolute numbers was among older women: 14% more women aged 35 years and older were sterilized in 1978 than in 1971. In 1978, 14% of women of reproductive age were surgically sterile.

[63] *Supra* n. 53.

(6) Rise of the Doctrine of Informed Consent

3.31 The role of the patient in medical decision making has gained prominence in recent years. The Supreme Court of Canada underscored its importance in its 1980 pronouncements in the cases of *Reibl* v. *Hughes*[64] and *Hopp* v. *Lepp*[65] on the doctrine of informed consent. As a result of these judgments, physicians became increasingly aware of their potential liability should they fail to obtain proper authorization before performing surgery or administering other treatment. The decision to sterilize a mentally incompetent person could no longer safely be looked upon as a decision to be entrusted to medical judgment. The limits of the authority of parents or guardians to consent to treatment on behalf of persons in their charge were questioned. Physicians were left facing the vexing problem of how to obtain a valid consent on behalf of a mentally incompetent patient. This is a ninth development.

C. CURRENT PRACTICES: INCIDENCE OF STERILIZATION

3.32 Our information about the performance of sterilization on minors and mentally incompetent adults is extremely sparse. We do not have statistics on the number of sterilizations performed annually on mentally incompetent persons in Alberta. However, we have obtained sterilization data for the total population for the years 1981 to 1986 inclusive. The data cover (i) male sterilization by vasectomy (Table 1); (ii) female sterilization by laparotomy, laparoscopy and colpotomy (Table 2); and (iii) female sterilization by hysterectomy (Table 3).[66] The figures appear by age groups commencing with under 1, continuing in five-year clusters from 1-4 to 50-54, and ending with over 54. We also have figures recording the use of the same procedures on minors for the years 1976 to 1978 (Table 4).[67] They are set out in the same lower age groups ending with a group for ages 15 to 17. All four tables are reproduced in Appendix E.

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[64] [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1.

[65] [1980] 2 S.C.R. 192, 13 C.C.L.T. 66. *See infra* paras. 4.5-4.12.

[66] The Tables were compiled at our request by Health Economics & Statistics, Alberta Hospitals & Medical Care. The annual dates reflect statistical year-ends of March 31.

The statistics were supplied with two caveats. First, due to the time interval between the date when the service was rendered by the physician and the date when the service was paid by the AHCIP, the number of services which were paid during each year may not represent the number of services which were rendered in each year.

Second, the recipient of the sterilization procedure has been identified on the basis of the AHCIP registration number which the practitioner reported for the patient on the claim submission. Due to possible errors in the submission of registration numbers, some caution should be exercised in interpreting the age breakdown of the services as some inaccuracies may exist in this data.

3.33 The figures do not provide the reasons for the sterilization nor do they reveal whether the operation was consented to by the patient or by someone else on his behalf. However, some of the sterilizations included in these figures will have been performed on mentally incompetent persons.

(1) Sterilization for Contraception

3.34 In interpreting the statistics on sterilization we have concentrated our attention on the figures for minors and young adults. We think it fair to assume that most, if not all, of the persons aged 19 years or under and a substantial number of those aged 20 to 24 who were sterilized by vasectomy or tubal occlusion will have been mentally disabled.

3.35 The information on which we base our assumption is as follows. First, these procedures are used infrequently for the purpose of medical treatment. Vasectomy plays virtually no role in medical treatment and birth control is by far the most common reason for tubal occlusion. Second, we have no evidence that sterilization is being widely performed on normally maturing but not yet mentally competent minors and we think it likely that the number of mentally competent young adults or mature minors seeking sterilization for contraception is low. Third, it is our impression that physicians generally are reluctant to sterilize mentally competent young persons for contraception.

3.36 We turn now to the statistics.

(a) Males

3.37 In 1986, 5,289 vasectomies were performed on Alberta males. Of these none were under 20 years of age. There is an observable pattern of slight but steady decline in the number of vasectomies performed on males 19 years or under in the 6-year period from 1981 to 1986 (from 6 vasectomies in 1981 to none in 1986). The figures for the 20 to 24 age group have fluctuated, showing a low of 120 in 1983 and a high of 163 in 1984. The figures for minors in the years 1976 to 1978 show 1 vasectomy in 1976, 6 in 1977 and 1 in 1978.

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[67] This Table was also compiled at our request by Health Economics and Statistics, Alberta Hospitals & Medical Care. The Department explains that a more current breakdown of the figures on the basis of minority is not available from the statistical report used to obtain the sterilization data. The data in that report are given for the 15 to 19 age group as a whole, rather than by single age.

(b) Females

3.38 In 1986, 10,876 sterilizations by laparotomy, laparoscopy or colpotomy were performed on Alberta females. Three were performed on females in the 10 to 14 age group, 43 on females in the 15 to 19 age group and 1,233 on females in the 20 to 24 age group. The figures for the years 1981 to 1985 are roughly comparable for females in the younger age groups. The figures for females aged 20 to 24 vary from a low of 972 in 1983 to a high of 1,098 in 1984.

3.39 From 1976 to 1978, sterilizations using these procedures were performed on a total of 11 minor females (2 in 1976, 4 in 1977 and 5 in 1978). The figures are difficult to compare with those available for 1981-1986 because the earlier line is drawn at age 17, not 19. However, it is possible that the number of sterilizations performed on young women has increased since that time.

(2) Hysterectomy for Menstrual Management

3.40 As with sterilization for contraception, the medical justifications for performing a hysterectomy on a young woman are rare and it can, we think, be fairly speculated that the hysterectomies recorded in the young age groups were performed on mentally disabled females for the purposes of menstrual management, contraception, or both.

3.41 In 1986, 6,295 hysterectomies were performed on Alberta females. One was performed on a female in the 10 to 14 age group and 16 on females in the 15 to 19 age group, for a total of 17. One hundred and twenty hysterectomies were performed on females in the 20 to 24 age group. The 1986 figures for the 19 and under age groups are slightly lower than in most previous years. The figures for the 20 to 24 age group vary between a high of 139 in 1981 and a low of 94 in 1983.

3.42 These numbers are similar to those recorded for minor females from 1976 to 1978.[61] The 1976-1978 figures, however, do not include females aged 18 to 19. If they did, the figures might be higher and permit the conclusion that there has been a reduction, since then, in the number of hysterectomies performed on women aged 19 and under.

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[61] In 1976, 18 hysterectomies were performed on females aged 10-14 and 8 on females aged 15-17 for a total of 26. In 1977, 1 hysterectomy was performed on a female aged 5-9, 20 on females aged 10-14 and 12 on females aged 15-17 for a total of 33. In 1978, 1 hysterectomy was performed on a female aged 5-9, 11 on females aged 10-14 and 7 on females aged 15-17 for a total of 19.

CHAPTER 4: THE CURRENT LAW

4.1 The present law relating to sterilization of mentally disabled persons is complex and controversial. It is complex because it is found in several different common law and statutory provisions and the exact ambit of that law is uncertain. It is controversial because the Supreme Court of Canada has recently ruled that a non-therapeutic sterilization can never safely be determined to be in the best interests of a mentally disabled person.

4.2 Because sterilizing procedures are performed by physicians, in this chapter we will look first at the requirements of the doctrine of informed consent in medical decision making. We mentioned the rise of this doctrine in Chapter 3. With some exceptions, the informed consent of a competent patient is required to administer medical treatment.

4.3 A physician cannot rely on the consent of a person who is not in fact mentally competent. In such a case, a substitute source of authority must be found. We will therefore look next at the provisions made by the law for substitute decision making on behalf of minors and mentally incompetent adults and the application of these principles to medical treatment decisions. (We have defined mental incompetence as the ability to make a legally binding decision for a given purpose. We have also identified the sources of mental incompetence as minority (being under the age of 18 years) or mental disability (having a condition, such as mental retardation, *dementia* or mental illness, that adversely affects mental functioning).)

4.4 Finally, we will look at the extension of these principles to sterilization decisions.

A. THE DOCTRINE OF INFORMED CONSENT

(1) The Elements

4.5 A valid consent has three elements. The patient must be competent to give a consent, know the procedure being consented to and agree voluntarily to its performance.[69] Subject to certain exceptions, all three elements must be present to protect the physician performing a surgical operation or medical procedure from criminal and civil liability.

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[69] Bernard M. Dickens, *supra* n. 17 at 265.

(a) Informed

4.6 The physician has a duty to tell the patient what he needs to know in order to exercise his right of decision. There are two aspects of the duty to inform. The first relates to the physician's liability in "battery"; the second to the physician's liability in "negligence".

4.7 As to the first aspect, the law says that the principle of the inviolability of the person protects the body of the patient from any touching to which he has not given consent. As one scholar explains:[70]

> A doctor who performs medical treatment without his patient's consent commits the tort of battery; to use more familiar language, he assaults his patient. He is therefore liable to pay damages if sued by the patient, notwithstanding that he was acting in what he considered his patient's "best interests". (Footnote omitted.)
>
> . . . . .
>
> [T]he amount of information required to ensure the validity of the patient's consent [in order to avoid liability in battery] is quite minimal. A brief description of the procedure and what it is hoped it will achieve is probably sufficient.

4.8 As to the second aspect, the law says that even if the patient has consented the consent will not protect the physician from liability in negligence if the physician did not give the patient the required level of information before obtaining the consent. To avoid liability in negligence, notwithstanding the validity of the consent, the physician must satisfy the following principles laid down by the Supreme Court of Canada in *Reibl v. Hughes*:[71]

> (i) A doctor must disclose those risks which he knows or ought to know a reasonable person in his patient's position would want to be told.
>
> (ii) In particular, the doctor must disclose all "material, unusual or special risks" involved in the proposed treatment.
>
> (iii) The doctor must answer fully any question asked by the patient relating to the risks of the proposed treatment.

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[70] Gerald Robertson, "Consent in Canadian Psychiatry". Unpublished Paper delivered at the Annual Meeting of the Alberta Psychiatric Association, held in Banff, Alberta. October 1984 at 1-2 and 5-6.

[71] *Supra* n. 64 at 8-9.

Notwithstanding the operation of these principles, "[t]he doctor may be entitled to withhold information if his patient is not 'able to cope with it because of emotional factors'".[72]

(b) Voluntary

4.9 The consent must be given freely and not under coercion or duress. The patient must be aware of his right to accept or refuse the treatment, and must exercise his own will in making the decision. This requirement needs to be looked at closely in the case of a mentally disabled person whose dependency may render him particularly susceptible to pressured "persuasion" by others.

(c) Competent

4.10 Competence to consent to medical treatment "is most frequently expressed in terms of the patient having the capacity to understand and appreciate the nature of the proposed treatment" and its consequences.[73] This description embraces the ability to comprehend the elements that are part of the law of treatment, that is, the benefits and risks of undergoing the procedure compared with the risks attendant upon not doing so.

(2) The Exceptions

(a) Emergencies

4.11 Emergency treatment may be given to a patient who is unable to consent in a situation that seriously threatens his life or physical health.[74] The exception would permit a surgical operation that sterilizes to be performed for the purpose of medical treatment but not for the purpose of contraception or menstrual management. The emergency exception applies whether the patient is mentally competent (e.g. no time to take consent, patient unconscious) or incompetent.

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[72] *Id.* at 9.

[73] *Supra* n. 70 at 4.

[74] The Ontario Bill described in Appendix J, defines an emergency as a situation in which delay in the provision of treatment "would place the life, a limb or a vital organ" of a person "in imminent and serious danger" (s. 23).

(b) Other

4.12 Other exceptions which are not relevant to this discussion are created by statute, as in the case of a person hospitalized involuntarily for treatment of a serious psychiatric disorder[75] or the treatment of a person with a prescribed communicable disease.[76]

B. MEDICAL TREATMENT DECISIONS

(1) Minors

(a) Parental Authority

(i) Source

4.13 Provision must be made for the daily care and upbringing of children during their evolution to adulthood. The responsibility ordinarily falls to the parents, as the child's natural guardians, from whom an affection for the child is assumed to flow naturally. The need for care continues through minority, although as a child matures, he becomes increasingly capable of caring for himself and his mental competence to make personal decisions may be recognized for some purposes of the law.

4.14 The situation is described succinctly in a recent article on Canadian family law:[77]

> Children have limited intellectual, physical, social, psychological and economic resources. They are born in a state of total dependence, requiring constant care. As they mature, they gradually acquire the capacity to care for themselves. At some point they are deemed to be fully capable of caring for themselves, and become adults. At birth a child is not capable of exercising any rights on his own behalf; his parents, some other person or agency, or the state must do this. In certain matters, a child may acquire legal rights and responsibilities before becoming an adult. Upon becoming an adult, the former "child" acquires a full range of legal and citizenship rights, to be exercised in his own right.

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[75] Mental Health Act, R.S.A. 1980, c. M-13.

[76] Public Health Act, S.A. 1984, c. P-27.1, ss. 49, 50, 54 and 55 and the Communicable Disease Regulation, Alta. Reg. 238/85, s-s. 6(3) and Sched. 3.

[77] Nicholas Bala and J. Douglas Redfearn, "Family Law and the 'Liberty Interest': Section 7 of the Canadian Charter of Rights" (1983) 15 *Ottawa L. Rev*. 274 at 293.

(ii) Nature and Scope

4.15 The nature and scope of the authority of parents is not spelled out in statute, so the common law (i.e. judge-made law) is in effect.

4.16 The authority of parents, as guardians at common law, is far-reaching.[78] First, parents have the responsibility to provide their children with the "necessaries of life". These include food, clothing, shelter and *essential* medical treatment. Second, they have the responsibility to raise them. A desirable upbringing includes care, control, guidance and supervision, and involves making decisions on the child's behalf. Third, parents have the authority to make decisions about the child's education (which may involve discipline) and religious upbringing; to consent to the child's medical treatment or other health care; and to consent to the child's marriage. Fourth, they are expected to give the child love and affection.

4.17 The responsibility and authority of parents is to be exercised "for the welfare" or "in the best interests" of the child. It would cover a sterilization for medical treatment as we have defined it.

(b) Mature Minor

4.18 The responsibilities of guardians "dwindle" or diminish as the child approaches adulthood and becomes increasingly capable of providing for himself and making his own decisions. Different children mature at different rates. Therefore the extent of the diminution at any given age will vary from child to child and purpose to purpose until the child attains majority.[79]

4.19 Where a minor is mentally competent to make his own decision, the parental authority for the purpose ceases.

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[78] Whereas historically, it may have been correct to refer to the "rights and duties" of guardians, today it is more accurate to describe the function in terms of "powers and responsibilities": England. The Law Commission, *Family Law - Review of Child Law: Guardianship* (Working Paper 91) 9-10.

[79] *See Gillick* v. *West Norfolk Area Health Authority* [1985] 3 All E.R. 402 at 418-24 (H.L.); *Hewer* v. *Bryant* [1969] 3 All E.R. 578 at 582 (C.A.); *J.S.C. and C.H.C.* v. *Wren* (1986) 76 A.R. 115 at 117-18 (Alta. C.A.); *Johnston* v. *Wellesley Hospital* (1970) 17 D.L.R. (3d) 139 at 144-5 (Ont. H.C.).

4.20 Alberta has no statute dealing with the consent of minors to health care, so the common law is in effect. Under it, a minor who is able to understand and appreciate the nature of the proposed treatment and its consequences can give a valid consent.[80]

(c) Court-Appointed Guardians

4.21 Where the parents are unable or unwilling to assume the responsibility of caring for their child, the law provides for the appointment of another person as the child's guardian to act in the stead of or jointly with the parent. The provisions in Alberta legislation authorizing the appointment of a guardian by a Court are outlined in Appendix F.

4.22 Except to the extent that the authority of the guardian is circumscribed by the provisions of the Act or the terms and conditions of an order made under it, the common law is in effect. The nature and scope of the authority is essentially the same as the authority of a parent, although the guardian does not share the parent's duty to maintain the child from his own resources, or to give him love and affection.[81] Like a parent, the guardian would be responsible to provide the child with essential medical treatment and he would have the authority to make other medical treatment or health care decisions that are in the child's best interests.

(d) Limits of Guardianship Authority

4.23 The outer limits of the acceptable conduct of parents and guardians toward children in their charge are established by the criminal law[82] and child welfare legislation.[83] A child welfare intervention may be made for the child's protection where a parent or guardian fails "to obtain for the child or to permit the child to receive essential medical, surgical or other remedial treatment that has been recommended by a physician".[84] Following the child's apprehension, a director may authorize essential medical care that is recommended by at least two physicians or dentists.[85] He may do so without the guardian's consent. If, however, the apprehension was motivated by the guardian's refusal to permit the treatment, a court order is required.[86] These provisions have been used to obtain a blood transfusion for a child whose parents have refused consent because of their belief in the Jehovah's witness faith.[87] They could be invoked to obtain a hysterectomy, the consent for which has been denied by the parent of a minor female with uterine cancer.

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[80] *Id.*

[81] Walder G.W. White, "A Comparison of Some Parental and Guardian Rights" (1980) 3 *Can. J. Fam. L.* 219.

[82] For a brief account of the protections afforded by the criminal law, *see* Paul Atkinson, "What legal protection is there for young people who may be subject to physical or mental abuse?" (1986) 11 *Resource News 27* at 27-28.

[83] For a description of the relevant provisions of the Alberta Child Welfare Act, S.A. 1984, c. C-8.1, *see* Appendix G.

4.24 Arguably, a child welfare intervention could also be made to prevent the performance of a medical procedure, including a sterilization, that is not in the child's best interests. This is so because many of the words in the definition of "physical injury", one of the areas of risk justifying an intervention, describe instrusions that accompany surgical sterilizations.[88]

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[84] *Id.* at s-s. 1(2)(c).

[85] *Id.* at s-s. 20(1)(a).

[86] *Id.* at s-ss. 20(2) to (5).

[87] *R.E.D.M.* v. *Director of Child Welfare* [1987] 1 W.W.R. 327, 74 A.R. 23 (Alta. Q.B.); *Re R.K.*, unreported, 20 March 1987, J.D. of Edmonton 8703-03944 (Alta. Q.B.); affg. 79 A.R. 140 (Alta. Prov. Ct. Fam. Div.). An appeal to the Alberta Court of Appeal has been filed in *Re R.K.*.

[88] The areas of risk justifying an intervention include physical injury, emotional injury and sexual abuse by the guardian or others from whom the guardian is unable or unwilling to protect the child.

A "physical injury" is defined to involve a "substantial and observable injury to any part of the child's body as a result of the *non-accidental application of force* or an agent to the child's body that is evidenced by a laceration, a contusion, an abrasion, a scar, a fracture or other bony injury, a dislocation, a sprain, hemorrhaging, the rupture of viscus, a burn, a scald, frostbite, the loss or alteration of consciousness or physiological functioning or the loss of hair or teeth": *supra* n. 83 at s-s. 1(3)(b).

The definition of "emotional injury", on the other hand, does not appear to include "emotional injury" resulting to the child from sterilization. Emotional injury involves "substantial and observable impairment of the child's mental or emotional functioning that is evidenced by a mental or behavioural disorder, including anxiety, depression, withdrawal, aggression or delayed development". To justify an intervention under the Act, there must be reasonable and probable grounds to believe that the emotional injury is the result of rejection; deprivation of affection or cognitive stimulation; exposure to domestic violence or severe domestic disharmony; inappropriate criticism, threats, humiliation, accusations or expectations of or towards the child; or the mental or emotional condition of the guardian of the child or chronic alcohol or drug abuse by anyone living in the same residence as the child: s-s. 1(3)(a)(ii).

The definition of "sexual abuse" is not relevant in the present context. It involves inappropriate exposure or subjection to sexual contact, activity or behaviour:

4.25 In most cases, an order of a judge of the Provincial Court, or failing a Provincial judge a justice of the peace, must be obtained before a child may be apprehended.[89] However, no order for apprehension is required where "the child's life or health is seriously and imminently endangered because ... there is substantial risk that he will be physically injured".[90] This language could support an apprehension to prevent a sterilization of dubious medical purpose from being performed without court consideration.[91]

(e) Duty of Persons Having Charge of Another

4.26 In some circumstances, persons who are not guardians owe a duty to persons who are unable to look after themselves. The Alberta Maintenance Order Act and the Criminal Code both place a duty on parents, guardians and others to make basic provision for persons (including minors) in their charge.

4.27 The Alberta Maintenance Order Act,[92] in subsection 2(1), imposes a duty on the husband, wife, father, mother and children of an old, blind, lame, mentally deficient or impotent person to provide maintenance, including adequate food, clothing, medical aid and lodging. This section was introduced in a bygone era and is not now actively enforced. Its continued existence in our statute books nevertheless reinforces the principle that members of the family, or other persons

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[88](cont'd) s-s. 1(3)(c).

[89] *Id.* at s. 17.

[90] *Id.* at s-s. 17(9)(c). Guardianship remains unaltered pending disposition, following apprehension, under the Act; however, the director's powers are broad: s. 20.

[91] It is noteworthy that the Act places a duty on any person who believes that a child is in need of protection to report the matter to a director: *id.* at s-s. 3(1). The duty to report takes precedence over any duty of confidentiality or prohibition on disclosure existing in another statute: at s-s 3(2). On our analysis, the duty would include a physician, health care professional, educator, or any other person working with the child and his family or otherwise having knowledge of plans for the performance of a sterilization that is not in the child's best interest. The failure to comply could lead to a complaint by the director to the person's governing professional or occupational body: at s-s 3(5). The failure also constitutes an offence punishable by a fine of not more than $2,000 or, in default of payment, imprisonment for a maximum of 6 months.
Information that is privileged as a result of a solicitor-client relationship is excepted from the duty to report: s-s. 3(3).

[92] R.S.A. 1980, c. M-1.

having charge of a person who is disabled physically or mentally are responsible for the provision of medical and other care.

4.28 Section 197 of the Criminal Code imposes a similar duty, making it illegal for an adult caring for a person under 16 to endanger life or health by failing to provide the 'necessaries of life'.[93] The necessaries of life, for the purpose of this section, have been held to include medical care.[94] The duty to provide medical care carries with it the right to authorize that care.[95]

4.29 Both statutory provisions would cover procedures undertaken for the purpose of medical treatment in an emergency and, where the person is mentally incompetent, in a less urgent circumstance.

(f) *Parens Patriae* Jurisdiction of Court

4.30 Another source of substitute decision-making authority is the *parens patriae* jurisdiction exercisable by superior courts. Historically, this jurisdiction was exercised by the courts on behalf of the King who was the protector (literally the father) of his subjects and responsible to look after persons who were unable to look after themselves. In Alberta, the Judicature Act gives the Court of Queen's Bench the same jurisdiction and powers in "all matters relating to infants, idiots or lunatics" that the English Court of Chancery had on 15 July 1870.[96] The Court of Chancery was the court that exercised the King's *parens patriae* power over infants.

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[93] R.S.C. 1970, c. C-34, s-ss. 197(1)(a) and 2(a).

[94] *E.g. R.* v. *Brooks* (1902) 5 C.C.C. 372 (B.C.S.C.); *R.* v. *Lewis* (1903) 6 O.L.R. 132, 7 C.C.C. 261 (Ont. C.A.); *R.* v. *Cyrenne, Cyrenne and Cramb* (1981) 62 C.C.C. (2d) 238 (Ont. Dist. Ct.).

[95] This point was made in a recent Florida case, *Ritz* v. *Florida Patient's Compensation Fund* 436 So. 2d 987 (1983). The headnote says:

> Where mentally retarded, adult child was incompetent and had no legally appointed guardian, right to consent to medical or surgical treatment resided in child's parent who had legal responsibility to maintain and support child, not only in emergency situations, but where treatment was deemed necessary to correct some ailment or disability.

It was held in an Alberta case that the authority to treat carries with it the duty: *Re Osinchuk* (1983) 45 A.R. 132 (Surr. Ct.).

[96] R.S.A. 1980, c. J-1, s-s. 5(3)(a). *See also* s-s. 5(1)(a) and s. 7.

4.31 The *parens patriae* jurisdiction is broad, sweeping and expansive. The jurisdiction is capable of adaptation to meet changing times and situations. It eludes definition, and for that reason is unlikely ever to be fully replaced by statute. It continues to be available to fill in around the edges of protective legislation such as the Child Welfare Act.[97] Because the jurisdiction is a protective one, the *parens patriae* power, like the authority of the parents or guardians who are supervised under it, must be exercised for the benefit ("in the best interests") of the minor being protected.[98]

4.32 In recent years English and Canadian courts have extended the *parens patriae* jurisdiction to cases involving medical procedures.[99]

4.33 As in a child welfare case, the jurisdiction may be called upon to ensure that a child receives necessary medical treatment.[100] Alternatively, it may be invoked to enjoin the performance of a medical procedure that places the child's life or health at risk or is otherwise contrary to his best interests. That is to say, where the limit of a guardian's authority to authorize a sterilization is in question or where the benefit of a sterilization to a child or mentally incompetent adult is in dispute, the court has power to intervene.[101] In either case, the treatment in question could be a sterilization.

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[97] One might think that the Child Welfare Act provides a complete code for the protection of children so that the power of the Court of Chancery representing the Crown as *parens patriae* would be superseded. Canadian cases, however, hold to the contrary and the *parens patriae* jurisdiction of Canadian superior courts over infants is generally recognized: *See e.g., Re H.I.R.* (1984) 30 Alta. L.R. (2d) 97 (Alta. C.A.); *Lutz* v. *Legal Aid Manitoba* (1982) 37 A.R. 351; 29 R.F.L. (2d) 337 (Alta. C.A.); *Beson* v. *Director of Child Welfare for Province Newfoundland* (1982) 44 N.R. 602; 39 Nfld. & P.E.I. R. 236; 111 A.P.R. 236; 142 D.L.R. (3d) 20 (S.C.C.).

[98] *See Re Eve, supra* n. 2 for a comprehensive discussion of the origins, nature and scope of the *parens patriae* power in Canada. In the judgment in that case the *parens patriae* jurisdiction is described as a jurisdiction that is for the benefit of the person and is founded on necessity; that eludes definition; that is preventive as well as retrospective; that is an expanding jurisdiction; that is a jurisdiction for which far-reaching limitations in principle must nevertheless exist; that must be exercised in accordance with its underlying principle, that is, to do what is necessary for the protection of the person for whose benefit it is exercised; that cannot be exercised in the interests of others; and that is at all times to be exercised with caution.

[99] *See* e.g. *Re Eve, id.* at 19-22, citing cases involving the following medical procedures: (i) a blood test: *Re S.* v.*McC*; *W.* v. *W.* [1972] A.C. (H.L.); (ii) non-therapeutic sterilization: *Re D (A Minor)* [1976] 1 All E.R. 326 (jurisdiction assumed but discretion not exercised); (iii) an abortion: in *Re P (A Minor)* (1981) 80 L.G.R. 301 (permitted for a 15 year old girl who could not cope with a second child; (iv) an operation to remove an intestinal blockage: *Re B (A Minor)* (1982) 3 F.L.R. 117; (v) the giving of a blood transfusion to save a child's life over its parents religious objection; and (vi) a hysterectomy: *Re K, supra* n. 16 (on the grounds that the operation was therapeutic: "... this case cannot and must not be regarded as a precedent to be followed in cases involving sterilization of mentally disabled persons for contraceptive purposes", *per* Anderson J.A. at 275).

[100] *E.g. Re S.D.* (1983) 145 D.L.R. (3d) 610 (B.C. S.C.).

(2) Mentally Incompetent Adults

4.34 Most children mature to competence and, by the time they reach 18 years of age, are able to assume the full rights and responsibilities of citizens. For this reason the law presumes the mental competence of adults. But not all adults are in fact mentally competent. The presumption of mental competence is therefore rebuttable.

4.35 Like children, mentally incompetent adults need protection. The common law, however, does not make certain provision for the guardianship of mentally incompetent adults (although the *parens patriae* jurisdiction of the superior courts does play a role here). Alberta enacted the Dependent Adults Act in 1976,[102] making it the first jurisdiction in Canada to pass detailed legislation dealing with personal decision making for mentally incompetent adults.[103]

(a) Court-appointed Guardianship: Dependent Adults Act

4.36 The Dependents Adults Act statutorily empowers the Surrogate Court[104] to appoint a guardian to make decisions for a "dependent adult". According to the Act, a "dependent adult" is a person who is repeatedly and continuously unable (i) to care for himself, and (ii) to make reasonable judgments in respect of matters relating to his person.[105]

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[101] We made recommendations for the reform of the law on the consent of minors to health care in our Report No. 19 issued in December 1975. In that Report, we recommended that a minor should not be able to consent to sterilization for any purpose (Recommendation #6 at 30) and excluded surgical sterilization from the definition of health care in s. 1 of our proposed Act (at 62). Our recommendations have not been enacted to date.

[102] S.A. 1976, c. 63, now R.S.A. 1980, c. D-32, as am. S.A. 1985, c. 21. The Act came into effect on December 1, 1978.

[103] Concerns about the management of property had attracted most of the legislative attention previously in Alberta. Adequate arrangements for property management continue to be the focal point of the legislative provisions in force in other Canadian provinces and Commonwealth jurisdictions.

[104] *Supra* n. 102 at s-ss. 1(c) and 6(1).

4.37 The court may appoint a guardian for a dependent adult where it is satisfied both that the guardianship would be in the best interests of the dependent adult and that it would result in substantial benefit to him or her.[106]

4.38 The guardianship may cover a wide range of decisions having to do with personal matters or it may be restricted to only some of them: the court is directed to grant only the powers and authority that are necessary to protect the dependent adult's best interests.[107] Such decisions may be in any or all of the following areas:[108]

residential and living arrangements;
education and training;
social activities;
daily living routines (including diet and dress);
employment;
legal proceedings (excluding estate matters);
and health care.

The Court also has residual power to grant the guardian authority with respect to any other matters where it is required to protect the best interests of the dependent adult.[109]

4.39 The guardian is required to exercise his power and authority:[110]

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[105] *Id.* at s-s. 6(1).

[106] *Id.* at s-s. 6(2).

[107] *Id.* at s-s. 10(1).

[108] *Id.* at s-s. 10(2).

[109] *Id.* at s-s. 10(2)(j).

[110] *Id.* at s. 11.

(a) in the best interests of the dependent adult,

(b) in such a way as to encourage the dependent adult to become capable of caring for himself and of making reasonable judgments in respect of matters relating to his person, and

(c) in the least restrictive manner possible.

His decision takes effect as if it had been given by the dependent adult as a competent person.[111]

4.40 Protection against the possibility of the abuse of authority by the guardian is provided by careful selection of the guardian,[112] the conferral of power and authority that is no wider than necessary,[113] and subsequent review of the exercise by the guardian of his authority.[114] If the guardian has acted improperly or become unsuitable to continue as guardian, the Court can discharge him.[115]

4.41 As is noted above, a specific head of guardianship which may be conferred under the Dependent Adults Act is the authority to make health care decisions, that is, "to consent to any health care that is in the best interests of the dependent adult".[116] "Health care" is defined to include:[117]

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[111] *Id.* at s-s. 10(4).

[112] Before appointing a person as guardian, the Court must be satisfied of his suitability for the purpose and that he will act in the dependent adult's best interests: *id.* at s-ss. 7(1)(a) and (c). Persons whose interests will conflict with those of the dependent adult are excluded from the selection but the mere fact of being a relative or potential beneficiary does not pose a conflict: s-ss. 7(1)(b) and 7(1.1). To assess a potential guardian's suitability to be a guardian, the Court may require him to attend and answer questions: s-ss. 7(2).

[113] The Court has a duty to inquire whether guardianship would be in the best interests of and result in substantial benefit to the mentally disabled person: *id.* at s-s. 4(1). Moreover, the Court is to confer only the powers and authority that are necessary: *supra* para. 4.38 and n. 107.

[114] When making a guardianship order, the Court must provide for its review no later than 6 years after the date of the order or its most recent review: *supra* n. 102 at s. 8. As part of the review the Court is to consider whether the guardian has acted in accordance with the order: *id.* at s. 16. The guardian therefore has to account to the Court for his conduct and decision.

[115] Any interested person may apply for an order to discharge a guardian. Grounds for discharge include failure to comply with the guardianship order and conduct endangering the dependent adult's well-being as well as intervening unsuitability for the task: *id.* at s. 19.

[116] *Supra* n. 109 at s-s. 10(2)(h).

> (i) any examination, diagnosis, procedure or treatment undertaken to prevent any disease or ailment,
>
> (ii) any procedure undertaken for the purpose of preventing pregnancy,
>
> (iii) any procedure undertaken for the purpose of an examination or diagnosis,
>
> (iv) any medical, surgical, obstetrical or dental treatment, and
>
> (v) anything done that is ancillary to any procedure, examination or diagnosis.

4.42 A guardian's authority "to consent to any health care that is in the best interests of the dependent adult"[118] undoubtedly includes consent to a sterilization for medical treatment.[119] The unanswered question is: does the inclusion of the words "any procedure undertaken for the purpose of preventing pregnancy" in the definition of "health care" mean that the court can authorize a guardian to consent to a sterilization for another purpose? A sterilization for contraception or hysterectomy for menstrual management has the effect of "preventing pregnancy" but its purpose is not "health care".[120]

(b) No Guardian

4.43 Where there is no guardian, section 20.1 of the Dependent Adults Act permits a physician to treat without consent on the written opinion of two physicians that the mentally incompetent person is "in need of an examination or medical, surgical or obstetrical treatment".

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[117] *Id.* at s-s. 1(h).

[118] *Id.* at s-s. 10(2)(h).

[119] Mental health treatment decisions for a person who has been hospitalized involuntarily under the Mental Health Act have been held to be excepted from a guardian's authority to make health care decisions for a dependent adult: *Re Osinchuk, supra* n. 95. It is unclear who would have the authority to consent to sterilization for medical treatment, contraception or menstrual management in this situation.

[120] In a press release dated July 8, 1975, the Cabinet Minister who introduced the Dependent Adults Act into the Legislature referred with approval to a departmental publication which stated: "This is not a provision to give effect to consents to experimental surgery, or involuntary sterilization".

The procedure cannot be undertaken if, to the knowledge of either physician, the mentally incompetent person has previously withheld consent while competent. The treatment may proceed "in the manner and to the extent that is reasonably necessary and in the best interests of the person examined or treated" as if the person had given consent.

4.44 One Alberta judge has suggested that section 20.1, which was in the Emergency Medical Aid Act until 1980,[121] is appropriate only for short term measures.[122] Its application may be limited to medical treatment and may even be further limited to urgent situations.

(c) Duty of Persons Having Charge of Another

4.45 Subsection 2(1) of the Maintenance Order Act[123] applies to mentally incompetent adults as well as children. The duty under s. 197 of the Criminal Code to provide necessaries of life is owed by any person having another person inescapably under his charge.[124] The other person could be a mentally incompetent adult. Thus, although a close relative or spouse is not a guardian in the sense that a parent is the guardian of his or her minor children, he or she may be under a statutory duty to provide medical care. So may be an institution in which a mentally disabled person is being cared for.

(d) *Parens Patriae* Jurisdiction of Court

4.46 It is probable that the *parens patriae* jurisdiction of the superior courts operates as a source of protection for mentally incompetent adults. Although there is some doubt about the jurisdiction of the Court of Queen's Bench to make decisions for adult persons who are unable to look after themselves,[125] recent Canadian cases accept that the jurisdiction exists.[126] It is probable that if the question were raised, the Dependent Adults Act, like the Child Welfare Act, would not be held to provide a complete code and that the *parens patriae* jurisdiction could be invoked with respect to matters left open by the Act.

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[121] R.S.A. 1980, c. 7 (supp.), s. 1.

[122] McDonald J. in *Re Osinchuk, supra* n. 95.

[123] *Supra* n. 92.

[124] *Supra* n. 93 at s-s. 197(1)(c).

[125] *Supra* n. 4.

[126] *Re Eve, supra* n. 2; *Institute Philippe Pinel* v. *Dion, supra* n. 21.

C. OTHER STERILIZATION DECISIONS

(1) Legal Uncertainty Pre-*Eve*

4.47 The repeal of the Sexual Sterilization Act in 1972 left Alberta without a statute on sterilization.[127] In the absence of specific statutory authority, Albertans, like persons living elsewhere in Canada, had to look to more general statutory provisions or the common law for the authority, if such existed, to make a substitute decision about sterilization.[128]

4.48 The leading Canadian case is *Re Eve*, decided by the Supreme Court of Canada on October 23, 1986.[129] Prior to October 23, 1986, questions were being asked across Canada about the limits of the authority of parents, guardians and courts to consent to the sterilization of minors and mentally incompetent adults. Could a parent or guardian consent to sterilization for contraception or menstrual management on behalf of a mentally incompetent person? Or, was the authority of a parent or guardian limited to cases in which the destruction of the procreative power is incidental to medical treatment? Could courts consent in the exercise of their inherent jurisdiction? Or, was legislative authority required for them to do so? What limitations had to be observed?

4.49 Legal uncertainty reigned. Different answers were forthcoming in different parts of the country.

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[127] The only current provision of which we are aware that mentions the subject is s. 20 of the regulations under the Hospitals Act: R.S.A. 1980 c. H-11; The Operation of Approved Hospitals Regulations, Alta. Reg. 146/71, as am. It treats hysterectomy and sterilization separately, providing that:

> (1) A consultation by another physician, preferably one who is a specialist in the appropriate specialty, shall be held for all ...
>
> (c) hysterectomies in patients under 40 years of age, unless adequate provision to prevent criminal abortions is made in the medical staff by-laws; ...
>
> (e) operations for sterilization in both male and female patients; ...

[128] Although the rationale for the enactment of the eugenic sterilization statutes was subsequently scientifically discredited, the statutes had the advantage of setting out the governing substantive law, designating a specially constituted tribunal to make the sterilization decision and supplying procedural safeguards for decision: see Appendix C.

[129] *Supra* n. 2.

4.50 At the east coast, the Prince Edward Island Supreme Court had wrestled with the issue of whether it had *parens patriae* jurisdiction to order sterilization on the facts in the *Eve* case.[130] Eve was a 24-year old, physically attractive, at least mildly to moderately mentally retarded woman with limited learning skills. Eve had developed an affectionate relationship with a male student at the training school they both attended during the week. Eve's mother, a widow approaching sixty with whom Eve lived on weekends, wanted to avoid the possibility that Eve would become pregnant and have a child neither of them could care for. She therefore brought an application for an order that she be authorized to consent to Eve's sterilization.[131]

4.51 The trial judge had held that, at least in the absence of "clear and unequivocal statutory authority",[132] neither the court nor parents or others could authorize the performance of a surgical procedure on a mentally retarded person for a solely contraceptive purpose.[133]

4.52 An appeal panel, composed of three judges of the Prince Edward Island Supreme Court sitting in banco, were of the unanimous view that the Court had jurisdiction. Two judges[134] were prepared to authorize the sterilization for a contraceptive purpose. One of them[135] thought that the decision in such a case could be made by the doctor as medical adviser and the guardian without the need for court involvement. They found sufficient evidence to warrant the sterilization and directed that Eve's doctor and Eve's mother should be free to make the choice of whatever medical or surgical intervention was considered best for Eve's welfare. The third judge[136] did not think that Eve's interests had been adequately represented before the trial judge, so confined himself on appeal to the question of jurisdiction. He gave his opinion that a contraceptive procedure should only be authorized in exceptional cases for the benefit, welfare or protection of the person involved and after consideration of a substantial number of factors.

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[130] *Re Eve* (1981) 115 D.L.R. (3d) 283 (P.E.I.S.C.) *revg. Re E.* (1979) 10 R.F.L. (2d) 317 (P.E.I.S.C. Fam. Div.).

[131] For a full recitation of facts, *see infra* paras. 4.68-4.72.

[132] *Re E.* (1979) 10 R.F.L. (2d) 317 at 329.

[133] His position is set out in the judgment on appeal: *Re Eve* (1981) 115 D.L.R. (3d) 283 at 284-5 (per Large J.):

> He was concerned with the question of whether he had the authority or jurisdiction to authorize a surgical procedure on a mentally retarded person for contraceptive purposes. He found that in the absence of statutory authority, except for clinically therapeutic reasons, which he defined as the preservation of life or the safeguarding of endangered health, neither the parents nor others standing *in loco parentis* can legally consent to a surgical procedure which would deprive such persons of any of their faculties as human beings.

[134] *Id.* at 294 (Large J.) and 320 (Campbell J).

[135] *Id.* at 316 (Campbell J.).

4.53 By addendum to the judgment some five months later,[137] the court changed its position and placed Eve under its jurisdiction "for the sole purpose of facilitating and authorizing her sterilization". It declared,[138]

> We are unanimously of the opinion that the court has, in proper circumstances, the authority and jurisdiction to authorize the sterilization of a mentally incompetent person for non-therapeutic reasons [contraception or menstrual management]. The jurisdiction of the court originates from its *parens patriae* powers toward individuals who are unable to look after themselves and gives the court authority to make the individual a ward of the court.

The addendum reserved approval of the method of sterilization pending submissions by counsel on the "medically preferred surgical procedure".

4.54 In a second addendum, the court authorized sterilization by hysterectomy.[139]

4.55 Neither the trial nor appellate judgments of the Prince Edward Island Supreme Court suggested that a parent or guardian could validly authorize a sterilization for contraception or menstrual management without court authorization.

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[136] MacDonald J.

[137] Reported at (1981) 115 D.L.R. (3d) 283 at 320-1.

[138] *Id.* at 321.

[139] The addendum is dated January 22, 1981 and is referred to in the S.C.C. judgment, *supra* n. 2 at 8. It does not indicate why this extreme method of sterilization was to be adopted. There is only one reference in the reported evidence to Eve's inability to cope with menstruation. One of the medical experts testified that: *supra* n. 130 at 291:

> ... despite good mothering and good teaching [Eve] hasn't yet been brought to the point where she can care for her pads for her menstrual period. She doesn't seem to be aware the mother tells me of when the pads are going to run out and this causes problems around her period, she doesn't seem to be aware of when her periods are starting and these are rather elemental things which one would expect her to be able to do given her demonstrated level of intelligence....

4.56 At the west coast, British Columbia, like Alberta, had repealed its eugenic sterilization statute[140] and had no statutory law governing sterilization when the case of *Re K* came to court.[141] *K* was a severely retarded, pre-menstrual, 10 year old girl who was alleged to suffer from a phobic reaction to blood.[142] K's mother brought an application for an order sanctioning her decision to have a hysterectomy performed on K.[143] She predicted, on the basis of K's past reactions to blood, that K would have an unmanageable hysterical reaction to her menstrual flow.[144] K's parents (K's

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[140] Sexual Sterilization Act, R.S.B.C. 1960, c. 353 repealed by S.B.C. 1973, c. 79.

[141] *Re K; K* v. *Public Trustee* [1985] 3 W.W.R. 204 (B.C.S.C.), reported on appeal *supra* n. 16.

[142] K's normal brain functioning had been destroyed by a rare disease known as tuberous sclerosis. She functioned at the level of a 26-month child. Her maximum lifetime prognosis was for the developmental level of a 42-month child. She had from five to thirty seizures a day, needed assistance with such ordinary tasks as washing, dressing and eating, and was not fully toilet trained. Her speech consisted of a few single word utterances although it was thought that she understood more than she was able to communicate. She displayed the basic emotions of love, fear and happiness. K had attended a special education program at a local public school since she was five, but her progress with basic skills was slow. She lived at home.

[143] One characteristic of tuberous sclerosis is the early onset of puberty and the doctors expected K to begin menstruating at any time.

[144] *Supra* n. 141 at 209-10. Three typical experiences forming the basis for this prediction were described in the trial judgment:

> Whenever she sustains an injury that bleeds, K constantly wipes the blood away, alternately staring at the spot and rubbing it with her hands. When the bleeding does not stop, she continues with an increase in tempo. She seems to become agitated and distressed although, unless the injury is severe, she does not cry, something she will do in appropriate circumstances. If she is distracted she will seemingly forget about both the injury and the blood.
>
> At one time she suffered from frequent spontaneous nosebleeds. ... She appeared to be fascinated by the blood and would smear it all over her face. As with an injury, the smearing motion would increase in tempo and in force as the bleeding continued. The reaction to blood from the nose was different from her reaction to, for example, excess mucus resulting from a bad cold, which she apparently just wipes away with the back of her hand unless assisted to blow her nose. Again it was necessary to distract her in some way to stop this reaction which included some signs of distress, albeit without tears.
>
> The most severe reaction occurs when blood samples are taken to test the balance of her seizure medications. As soon as K enters the laboratory room she becomes agitated. It takes three to four people to physically restrain her while the samples are

father agreed that the operation would be in K's best interests) wished to spare her from this further grief or stress.

4.57 The trial judge found that the beneficial purpose sought to be achieved by the hysterectomy was of an "uncertain and anticipatory nature".[145] He concluded that an order for hysterectomy was not in K's best interests at the time and denied the application.

4.58 The British Columbia Court of Appeal disagreed with him. It found the case put forward by the parents overwhelming, characterized the sterilization as "therapeutic", and granted the application.[146] It did not question the jurisdiction of the court to make the order. Instead, it took the view that the retention of K's right to reproduce was meaningless on the facts and that the decision should have been left to the parents. In the words of one of the judges, it should have been no more necessary to obtain the approval of the court in this case than in other cases "where parents after consultation with their medical advisors have authorized surgical operations in the best interests of the child".[147] The same judge gave his further view that the appropriate test is not whether the sterilization is "therapeutic" or "non-therapeutic" but whether it is or is not in the child's best interests,[148] thereby inferring that parents have the authority to take into account the minor's social as well as medical circumstances.

4.59 The members of the Court were so strongly of the view that the hysterectomy was in K's best interests that they refused to stay their decision pending the delivery of written reasons and an opportunity to appeal.[149]

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[144](cont'd) removed. She will occasionally cry, although generally she shows other signs of distress. Once that process is complete and she is released from restraint she runs from the room. She will then pick at the bandage until it is removed and she can rub or pick at the small puncture wounds on her arm. This reaction has grown progressively worse over the years, so much so that her doctor now orders fewer blood tests than he considers ideal.

[145] *Id.* at 237.

[146] *Supra* n. 16.

[147] *Id.* at 278 (per Anderson J.A.).

[148] *Id.* at 275.

[149] An application for leave to appeal made after the hysterectomy had been performed

4.60 In Ontario in 1978, the Minister of Health ordered a nine month public hospital moratorium on the sterilization, except for medical treatment, of persons under 16 years of age.[150] The moratorium is still in force.[151]

4.61 In Alberta, the Dependent Adults Act (which permits the Surrogate Court to appoint a guardian endowed with specific authority to consent to health care on behalf of a dependent adult) defined "health care" to include the "prevention of pregnancy".[152] There was doubt about the scope of the authority conferred by the inclusion of these words. Some judges specifically authorized the guardian to consent to the performance of a sterilization for contraception or menstrual management as part of the authority to consent to health care. Other judges specifically excluded sterilization from the guardianship order. Most guardianship orders were silent.

4.62 Because of the doubt, the Public Guardian had developed a practice of asking the court for directions in sterilization cases. The Public Guardian informs us that a number of applications were made and that sterilization for contraception, in some instances by hysterectomy, was authorized.[153] Before making a determination, some judges required a special hearing with

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[149](cont'd) was denied by the Supreme Court of Canada on a technical ground: [1985] 4 W.W.R. 757 (S.C.C.).

[150] The moratorium resulted from a paper given to the Toronto Psychiatric Association on 5 October 1978 by Dr. Zarfas, a psychiatrist. Dr. Zarfas stated that 308 sterilizations of minors were performed under the Ontario Health Plan in 1976. Fifty of the minors were males. For 109 of the 158 females the operation was hysterectomy. Dr. Zarfas thought that parents in Ontario

> ... tend to have these procedures carried out before the age of 16 because they are uncertain that the operation could be done when the person refuses to give consent and is over the age of 16.

(Sixteen is the age fixed by regulation in that province for consent to a surgical operation in a public hospital: R.R.O. 865 (under the Public Hospitals Act), s. 50.).

[151] R.R.O. 1980, Reg. 865 (under the Public Hospitals Act), s. 52:

> (1) ... no surgical operation for the purpose of rendering a patient or outpatient incapable of insemination or of becoming pregnant shall be performed where the patient or outpatient is under the age of 16 years.
>
> (2) Subsection (1) does not apply where the surgeon or the attending physician believes that the surgical operation is medically necessary for the protection of the physical health of the patient or outpatient.

[152] *Supra* n. 102 at s-s. 1(h)(ii).

[153] Although they are a matter of public record, copies of the orders are difficult to

independent representation of the dependent adult on the sterilization issue; others did not. Following the hearing some judges made the determination themselves; others left the decision to the guardian.

4.63 In a Saskatchewan case, a judge expressed sympathy for parents bearing the burden of care.[154] The person concerned was a big, retarded 12 1/2 year old female whose functional level was less than that of a two year old child. The issue of sterilization was not before the court directly.[155] The judge did, however, comment as follows:[156]

> This family has kept in its home a most severely handicapped child, with the enormous pressures and strains inherent in such a relationship. To suggest that those who have determined to do so must endure still greater burdens, burdens which are almost intolerable, is to turn rights and responsibilities upside down.

He went on to say:[157]

> It is obvious that a parent and a child can have a conflict of interests. But here the parents had decided to keep this child in their home, to the child's benefit, but at the eternal sacrifice of any normal home life for themselves or their other children. To add to that the burden of the menstrual cycle is not only to exaggerate the rights of the child at the expense of the rights of her parents, but is to fail to recognize that the parents, on whom this child must rely, have themselves a limit of endurance.

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[153](cont'd) obtain. First, the Public Guardian treats orders relating to persons under public guardianship as confidential. The Dependent Adults Act, *id.* s. 49, prohibits the disclosure of any file, document or information obtained by the Public Guardian pursuant to the Act that deals with the personal history or records of a dependent adult except at a proceeding under the Act, with the written consent of the Minister or where disclosure would be in the best interests of the dependent adult. Second, conducting a manual search for sterilization orders in the Surrogate Court files would have been a mammoth task and it was not feasible for us to attempt it.

[154] *Bell* v. *Society for the Promotion of Education and Activities for Children in the Home* (1984) 34 Sask. R. 203, 6 C.C.E.L. 156 (Q.B.) *affd.* (1986) 36 A.C.W.S. (2d) 442 (Sask. C.A.).

[155] The case involved an alleged wrongful dismissal. It was brought by a psychologist who, contrary to the express instructions of his employer, had meddled in arrangements being made by the parents to have a hysterectomy performed on the child.

[156] *Supra* n. 154 at 206.

[157] *Id.*

4.64 The constitutional entrenchment of rights under the Canadian Charter of Rights and Freedoms[158] added to the picture of legal uncertainty. The application of the Charter to sterilization cases remains, as yet, a largely uncharted territory. There are, however, three potentially significant sections to note. Two of those sections, section 7 and 12, came into force on 17 April 1982. Section 7 protects the right to life, liberty and security of the person.[159] Section 12 prohibits cruel and unusual treatment or punishment.[160] The third section, section 15, took effect on 17 April 1985,[161] just before the *Eve* case was argued in the Supreme Court of Canada. Section 15 protects equality rights.[162] All of the rights and freedoms guaranteed by the Charter are subject "to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".[163] Moreover, the legislature may expressly opt out of the provisions of the Charter to which we have referred.[164] In short, the rights and freedoms guaranteed by the Charter are not absolute. The court may provide a remedy for a person whose rights have been infringed.[165]

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[158] Enacted as Schedule B to the *Canada Act* 1982 (U.K.), c. 11. It came into force on 17 April 1982.

[159] The section says:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[160] It reads:

> Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

[161] The purpose of the three-year delay was to enable governments to bring their statutes into compliance with the provisions of section 15.

[162] It provides:

> (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[163] *Supra* n. 158 at s. 1: the "limitations clause".

[164] *Id.* at s. 33.

[165] *Id.* at s. 24. Arguments based on the Charter were made before the Supreme Court of Canada in *Re Eve*, *supra* n. 2.

4.65 In the law reform world, the Law Reform Commission of Canada had issued a Working Paper entitled "Sterilization: Implications for Mentally Retarded and Mentally Ill Persons" in 1979.[166] In Alberta we had delayed publication of our Report for Discussion (now substantially revised) pending delivery of the *Eve* judgment. The Manitoba Law Reform Commission had put its project on hold pending judgment in *Eve*.

4.66 In the absence of clear law either permitting or prohibiting them from doing so, a parent or guardian and physician sometimes collaborated in arranging for the sterilization of a mentally incompetent person. Concern was being expressed in some quarters[167] that sterilizations were being too freely undertaken. Those sounding objections were aware that the dependence of minors and mentally incompetent adults renders them vulnerable to having their wishes overridden by the will of other persons. Knowledge about past practices under laws permitting eugenic interventions contributed to social sensitivity on the issue. If it was not the cause of actual abuse, the absence of clear substantive and procedural protections raised sufficient potential for abuse in individual cases to justify the introduction of legal standards and safeguards.

4.67 Clarification was needed. Judicial guidance was wanted. It is as a thread in this fabric that the *Eve* case reached the Supreme Court of Canada.

(2) Judgment in the Supreme Court of Canada

(a) Facts

4.68 The facts of the *Eve* case are summarized above.[168] We will set them out here in more detail.

4.69 Eve was a 24 year old mentally retarded woman who also suffered from "extreme expressive aphasia". That is a condition in which "the patient is unable to communicate outwardly thoughts or concepts which she might have perceived".[169] The condition makes it exceedingly difficult for an expert to evaluate the person's actual perception and understanding.

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[166] *Supra* n. 12.

[167] *E.g.* by members of associations such as the Alberta Association for Community Living (formerly the Alberta Association for the Mentally Handicapped) devoted to promoting the interests of mentally disabled persons.

[168] *Supra* para. 4.50.

4.70 When Eve became 21 her mother sent her to a school for retarded adults in another community. There she struck up a close friendship with a male student. They talked of marriage. The situation was identified by the school authorities who talked to the male student and brought the matter to an end.

4.71 Mrs. E. feared that while unsupervised, Eve might become pregnant. She felt that Eve could not cope with motherhood and that the responsibility would fall on Mrs. E. She therefore brought application for permission to consent to Eve's sterilization.

4.72 The trial judge made the following findings:[170]

> The evidence established that "Eve" is 24 years of age, and suffers what is described as extreme expressive aphasia. She is unquestionably at least mildly to moderately retarded. She has some learning skills, but only to a limited level. She is described as being a pleasant and affectionate person who, physically, is an adult person, quite capable of being attracted to, as well as attractive to, the opposite sex. While she might be able to carry out the mechanical duties of a mother, under supervision, she is incapable of being a mother in any other sense. Apart from being able to recognize the fact of a family unit, as consisting of a father, a mother, and children residing in the same home, she would have no concept of the idea of marriage, or indeed, the consequential relationship between intercourse, pregnancy and birth.

The trial judge further concluded:[171]

> ... that Eve is not capable of informed consent, that her moderate retardation is generally stable, that her condition is probably non-inheritable, that she is incapable of effective alternative means of contraception, that the psychological or emotional effect of the proposed operation would probably be minimal, and that the probable incidence of pregnancy is impossible to predict.

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[169] *Supra* n. 132 at 318-9.

[170] *Id.* at 318 (McQuaid J.).

[171] *Id.* at 320.

(b) Decision

4.73 The judgment of the Supreme Court of Canada, written by La Forest J., was unanimous. It contains two main points.

4.74 First, the Supreme Court of Canada held that non-therapeutic sterilizations[172] lie beyond the reach of the court's ***parens patriae*** jurisdiction. In the words used by the Court:[173]

> The grave instrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the ***parens patriae*** jurisdiction.

Permission for Eve's sterilization, which the Court characterized as non-therapeutic, was consequently refused.

4.75 Secondly, the Supreme Court stated that if non-therapeutic sterilizations are to be permitted at all, then it is up to the legislature to enact legislation:[174]

> If sterilization of the mentally incompetent is to be adopted as desirable for general social purposes, the legislature is the appropriate body to do so. It is in a position to inform itself and it is attuned to the feelings of the public in making policy in this sensitive area.

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[172] *Supra* n. 2 at 28-9 and 34. A "therapeutic sterilization" includes a surgical operation that is necessary to the physical or mental health of the person. It may be performed as "an adjunct to treatment" of a serious medical condition. A "non-therapeutic sterilization", on the other hand, is not undertaken out of necessity, but instead may have a "purely social" purpose.

[173] *Id.* at 32.

[174] *Id.* at 32-33. The judgment goes on to quote with approval the following passage from the American case, ***Re Guardianship of Eberhardy*** 307 N.W. 2d. 881 at 895 (1981):

> ... there has been a discernible and laudable tendency to "mainstream" the developmentally disabled and retarded. A properly thought out public policy on sterilization or alternative contraceptive methods could well facilitate the entry of these persons into a more nearly normal relationship with society. But again this is a problem that ought to be addressed by the legislature on the basis of factfinding and the opinions of experts.

(c) Reasons for Limiting the *Parens Patriae* Jurisdiction

4.76 Several reasons for limiting the *parens patriae* jurisdiction are evident from the judgment.

4.77 First, the Supreme Court appears to be impressed by the enormity of the consequences of sterilization. Statements in the judgment emphasize over and over again that sterilization is "in every case a grave intrusion on the physical and mental integrity of the person"[175] which "ranks high in our scale of values";[176] it "removes from a person the great privilege of giving birth";[177] and it is "for practical purposes irreversible".[178] Moreover, the sterilization decision "involves values in an area where our social history clouds our vision and encourages many to perceive the mentally handicapped as somewhat less than human".[179]

4.78 Second, the Supreme Court regards as demonstrably weak the four justifications "commonly proposed" in support of non-therapeutic sterilization: the trauma of birth, difficulty in coping as a parent, the relief of hygienic problems and the interests of caregivers.[180] In rejecting these justifications, the Court said:[181]

> 1. that it is difficult to show that the trauma of birth is greater for mentally handicapped persons than for others;
>
> 2. that the argument relating to fitness as a parent "involves many value-loaded questions" and human rights considerations should make a court extremely hesitant about attempting to solve social problems (e.g. the financial burdens involved) by sterilization;
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> 3. that a person who requires assistance with menstrual hygiene is also likely to require assistance with the more troublesome problems of urinary and fecal control and that, apart from this, the drastic

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[175] *Id.* at 34.

[176] *Id.*

[177] *Id.* at 29.

[178] *Id.*

[179] *Id.*

[180] *Id.* at 30. There was, according to the Court, "no evidence to indicate that failure to perform the operation would have any detrimental effect on Eve's physical or mental health".

[181] *Id.* at 31-2.

> measure of hysterectomy is clearly excessive for the purpose; and
>
> 4. that although one may sympathize with the interests of caregivers such as Eve's mother, the *parens patriae* jurisdiction is not available for their benefit.

4.79 Third, the Supreme Court asserts that judges generally do not have adequate knowledge to make non-therapeutic sterilization decisions. According to the Court:[182]

> Judges are generally ill-informed about many of the factors relevant to a wise decision in this area. They generally know little of mental illness, of techniques of contraception or their efficacy.

Moreover, the court process is inadequate to sufficiently inform them: "[H]owever well presented a case may be, it can only partially inform".[183]

4.80 Fourth, the Supreme Court expresses misgivings about the sufficiency of "best interests" as the basis for decision:[184]

> ... the best interests test is simply not a sufficiently precise or workable tool to permit the *parens patriae* power to be used in situations like the present ...

According to the Court:[185]

> it is difficult to imagine a case in which non-therapeutic sterilization could possibly be of benefit to the person on behalf of whom the court proposes to act, let alone one in which that procedure is necessary in his or her best interest.

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[182] *Id.* at 32.

[183] *Id.*

[184] *Id.* at 33. The Court goes on to quote a passage from the judgment in an American case, *Re Guardianship of Eberhardy*, *supra* n. 174 at 894 (*per* Heffernan J.) which includes the following words:

> No one who has dealt with [the "best interests"] standard has expressed complete satisfaction with it. It is not an objective test, and it is not intended to be. The substantial workability of the test rests upon the informed fact-finding and the wise exercise of discretion by trial courts engendered by long experience with the standard.

[185] *Id.* at 32.

4.81 Fifth, the Supreme Court takes the view that the principle that the ***parens patriae*** jurisdiction is to be exercised with great caution[186] precludes it from exercising its discretion in favour of a non-therapeutic sterilization, especially where, as here, an error is irreversible.[187] The Court articulates the fear that the omission to proceed with caution "would open the way to abuse of the mentally incompetent".[188]

(d) Precautions About Legislation

4.82 What is needed, according to the Supreme Court are "well thought-out policy determinations reflecting the interest of society, as well as of the person to be sterilized".[189] The Court recognizes the legislature as the appropriate body to set out this policy.[190] At the same time the judgment contains reservations that any legislature making the attempt must keep in mind.

4.83 First, the basic human right to procreate is involved. Therefore, any legislation permitting non-therapeutic sterilization must be written in clear and unequivocal language.[191]

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[186] The point is made repeatedly in the judgment, as the following statements illustrate:

> "[The discretion] must be exercised in accordance with its underlying principle. Simply put, the discretion is to do what is necessary for the protection of the person for whose benefit it is exercised.": *id.* at 29;
>
> "I ... repeat that the utmost caution must be exercised commensurate with the seriousness of the procedure.": at 30.

[187] *Id.* at 32, where it is said:

> Unlike other cases involving the use of the ***parens patriae*** jurisdiction, an error cannot be corrected by the subsequent exercise of judicial discretion. That being so, one need only recall Lord Eldon's remark [in ***Wellesley's*** case, 2 Russ. 1 at 18, 38 E.R. 236 at 242] that "it has always been the principle of this Court, not to risk damage to children ... which it cannot repair" to conclude that non-therapeutic sterilization may not be authorized in the exercise of the ***parens patriae*** jurisdiction.

[188] *Id.* at 37. "In conducting these procedures, it is obvious that a court must proceed with extreme caution; otherwise ... it would open the way for abuse of the mentally incompetent."

[189] *Id.* at 33, quoting from ***Re Guardianship of Eberhardy, supra*** n. 174 at 895.

[190] ***Supra*** n. 174 and corresponding text.

[191] ***Supra*** n. 130.

4.84 Second, the sterilization of minors and mentally incompetent adults must be recognized for what it is:[192]

> ... the question is whether there is a method by which others, acting on behalf of the person's best interests and in the interests, such as they may be, of the state, can exercise the decision. Any governmentally sanctioned (or ordered) procedure to sterilize a person who is incapable of giving consent must be denominated for what it is, that is, the state's intrusion into the determination of whether or not a person who makes no choice shall be allowed to procreate.

4.85 Third, the guidelines provided must be well thought-out.[193]

4.86 Fourth, certain minimal evidential and procedural standards must be satisfied. Three such standards are specified for borderline cases, which are to be brought to court. One has to do with the onus of proof that sterilization is in the best interests of the mentally incompetent person. The onus lies with the person seeking to have the sterilization performed.[194] The next has to do with the burden of proof. That burden, "though a civil one, must be commensurate with the seriousness of the measure proposed".[195] The third has to do with representation of the mentally incompetent person. It is, in the words of the Court, "essential that the mentally incompetent have independent representation".[196]

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[192] *Supra* n. 2 at 35, quoting from *Re Guardianship of Eberhardy, supra* n. 174 at 893. Compare this statement with the words of Lord Oliver in *Re B (A Minor), supra* n. 4 at 219:

> ... this case is not about sterilisation for social purposes; it is not about eugenics; it is not about the convenience of those whose task it is to care for the ward or the anxieties of her family; and it involves no general principle of public policy. It is about what is in the best interests of this unfortunate young woman and how best she can be given the protection which is essential to her future well-being so that she may lead as full a life as her intellectual capacity allows. That is and must be the paramount consideration...

[193] *Supra* para. 4.82 and n. 189.

[194] *Supra* n. 2 at 37.

[195] *Id.*

[196] *Id.*

4.87 Fifth, the Supreme Court warns that the actions of the legislature will "be subject to the scrutiny of the courts under the *Canadian Charter of Rights and Freedoms* and otherwise".[197]

(e) Conclusion

4.88 In limiting its jurisdiction as it has in the *Eve* judgment, the Supreme Court of Canada has vividly underscored the seriousness of sterilization as an intervention:[198]

> The irreversible and serious intrusion on the basic rights of the individual is simply too great to allow a court to act on the basis of possible advantages which, from the standpoint of the individual, are highly debatable.

(3) *Re B*: A Starkly Contrasting View

4.89 Just over six months after the Supreme Court of Canada delivered judgment in *Re Eve*, the case of *Re B*[199] was decided by the House of Lords, England's highest appellate court.[200] *Re B* squarely raised the issue of the scope of application of the *parens patriae* jurisdiction of the superior courts, and a starkly contrasting point of view emerged. The view was held unanimously by the trial judge, the three justices of the Court of Appeal and the five members of the House of Lords before whom the case was argued.

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[197] *Id.* at 33.

[198] *Id.* at 32.

[199] *Re B (A Minor), supra* n. 4. By comparison with the *Eve* case, *Re B* fairly sped through the court system. The initial application was heard by the Family Division on January 20, 1987, it went to the Court of Appeal on March 16 and was heard by the House of Lords on April 30, 1987. *Re Eve* dragged through the courts from June 14, 1979 until October 23, 1986.

[200] At the time *Re Eve* was decided, the only English case directly on point was *Re D*, heard by Mrs. Justice Heilbron of the High Court (Family Division): [1976] 1 All E.R. 326.

D was an 11 year old girl who had been born with Sotos Syndrome. D's intelligence was in the dull normal range; her understanding was that of a 9 to 9.5 year old child. Her mother, worried that D would become pregnant, had arranged for a physician to perform a hysterectomy to prevent pregnancy. A psychologist who had been working with D brought proceedings to prevent the sterilization from being performed. The evidence established that D was able to attain a fair academic record at a special school and possessed sufficient intellectual capacity to marry.

Mrs. Justice Heilbron made D a ward of the court to prevent the proposed hysterectomy, saying, in words quoted with approval by the SCC in *Re Eve*, that "the type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce, and therefore it would, if performed on a woman for *non-therapeutic* reasons and without her consent, be a violation of such right" (Emphasis added): at 332.

The decision in *Re D* made it clear that the parent of a minor could not consent to the minor's sterilization for a purpose other than medical treatment. The court did not have to decide whether it had *parens patriae* jurisdiction to order sterilization because it held that it would not be in D's best interest for the sterilization to be performed.

(a) Facts

4.90 The case of *Re B* involved the sterilization of Jeanette, a 17 year old moderately retarded girl.

4.91 Jeanette, who was physically mature, had begun to exhibit the signs of a normal sex drive.[201] Her conduct prompted those responsible for her care to become concerned about pregnancy. The local authority (in Alberta, compare a director under the Child Welfare Act) brought a court application for permission for her to undergo a sterilization. Jeanette's mother, whom she visited on weekends, supported it.

4.92 Jeanette had the comprehension and functional ability of a six year old but was able to speak in sentences of only one or two words. She was capable of "finding her way round a limited locality, of dressing and bathing herself and performing simple household tasks under supervision and she [had] been taught to cope with menstruation".[202] She understood the link between pregnancy and a baby but was unaware of sexual intercourse and its relationship to pregnancy. She would not be capable of giving a valid consent to marriage or of making an informed choice about birth control.

4.93 Pregnancy presented "formidable"[203] risks for Jeanette:[204]

> She would not understand or be capable of easily supporting the inconveniences and pains of pregnancy. As she menstruates irregularly, pregnancy would be difficult to detect or diagnose in time to terminate it easily. Were she to carry a child to full term she would not understand what was happening to her, she would be likely to panic, and would probably have to be delivered by Caesarian

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[201] The signs included making provocative approaches to male members of the staff and other residents of the institution where she lived and touching herself in the genital area: *supra* n. 4 at 216, *per* Lord Oliver. She had once been found in a compromising situation in a bathroom: at 212, *per* Lord Hailsham.

[202] *Id.* at 216, *per* Lord Oliver.

[203] *Id.*

[204] *Id.* at 212, *per* Lord Hailsham.

> section, but, owing to her emotional state, and the fact that she has a high pain threshold she would be quite likely to pick at the operational wound and tear it open. In any event, she would be "terrified, distressed and extremely violent" during normal labour. She has no maternal instincts and is not likely to develop any. She does not desire children, and, if she bore a child, would be unable to care for it.

4.94 Other birth control methods were unsatisfactory. Mechanical means were ruled out by her limited intelligence. Finding a suitable oral contraceptive also presented problems. For one thing, Jeanette was obese and an oral contraceptive that had been tried had to be abandoned because it led to an excessive weight gain. For another, the effectiveness of the contraceptive would be difficult to determine because it would have to be taken in combination with an anticonvulsant drug she took for epilepsy and another drug, danazole, administered to control extremes of mood, violence and aggression associated with pre-menstrual tension. One physician testified that there would be only a 30 to 40 per cent chance of finding a successful formulation, and finding it could require 12 to 18 months of experimentation. In addition, the side effects of an oral contraceptive taken, without interruption, for the rest of Jeanette's fertile life were unknown and could be serious. Furthermore, the feat of daily administration would be hampered by Jeanette's mood swings and considerable physical strength: "As the social worker put it 'If ('B') is ... in one of her moods ... there is no way' she would try to give her a pill".[205]

(b) Decision

4.95 The House of Lords agreed with the applicant and Jeanette's mother that pregnancy would be contrary to Jeanette's best interests. In the circumstances, it had no difficulty holding that it had *parens patriae* jurisdiction to give "on [Jeanette's] behalf that consent which she is incapable of giving and which, objectively considered, it is clearly in her interests to give".[206] The House of Lords, like the trial judge and Court of Appeal before it, authorized Jeanette's sterilization by tubal occlusion.

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[205] *Id.*

[206] *Id.* at 218, *per* Lord Oliver who also agreed with Dillon L.J. in the Court of Appeal "that the jurisdiction in wardship proceedings to authorize such an operation is one which should be exercised only in the last resort".

4.96 In assessing the birth control alternatives, the Lords made the following observations:

1. The provision of close supervision during Jeanette's adult life by "[incarcerating] her or [reducing] such liberty as she is able to enjoy would be gravely detrimental to the amenity and quality of her life".[207]

2. An oral contraceptive would provide speculative protection, possibly be damaging and require "discipline over a period of many years from one of the most limited intellectual capacity".[208]

3. Sterilization by tubal occlusion would provide certain protection and have minimal detrimental effects:[209]

> The operation is relatively minor, "carrying a very small degree of risk to the patient, a very high degree of protection and minimal side effects".

However, it would be irreversible:[210]

> My Lords, the arguments advanced against the adoption of the expedient of a sterilisation operation are based almost entirely (and, indeed, understandably so) upon its irreversible nature.

(c) Rejection of the Supreme Court of Canada Position on the *Parens Patriae* Jurisdiction

4.97 The judgment of the Supreme Court of Canada in *Re Eve* was brought to the attention of the House of Lords. It emphatically rejected the Supreme Court's conclusion that sterilization should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction. The most stinging indictment of the Canadian position came from Lord Hailsham. He stated:[211]

> ... whilst I find La Forest J.'s history of the *parens patriae* jurisdiction of the Crown ... extremely helpful, I find, with great respect, his conclusion ... that the procedure of sterilisation 'should *never* be authorised for non-therapeutic purposes' totally unconvincing

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[207] *Id.* at 212 *per* Lord Hailsham.

[208] *Id.* at 218 *per* Lord Oliver.

[209] *Id.* at 217.

[210] *Id.* at 218.

[211] *Id.* at 213.

> and in startling contradictions to the welfare principle which should be the first and paramount consideration in wardship cases. Moreover, for the purposes of the present appeal I find the distinction he purports to draw between 'therapeutic' and 'non-therapeutic' purposes of this operation in relation to the facts of the present case above as totally meaningless, and, if meaningful, quite irrelevant to the correct application of the welfare principle. To talk of the 'basic right' to reproduce of an individual who is not capable of knowing the causal connection between intercourse and childbirth, the nature of pregnancy, what is involved in delivery, unable to form maternal instincts or to care for a child appears to me wholly to part company with reality.

4.98 Three main points are made in this passage and the judgments of the other Lords. First, the welfare or "best interests" principle is the basis for the exercise of *parens patriae* jurisdiction. This point is illustrated in the following passage from the judgment of Lord Oliver:[212]

> ... this case is not about sterilisation for social purposes; it is not about eugenics; it is not about the convenience of those whose task it is to care for the ward or the anxieties of her family; and it involves no general principle of public policy. It is about what is in the best interests of this unfortunate young woman and how best she can be given the protection which is essential to her future well-being so that she may lead as full a life as her intellectual capacity allows. That is and must be the paramount consideration ....

4.99 Second, the distinction between the purpose of the sterilization as therapeutic or non-therapeutic does not assist the determination of best interests. This point is underscored in the following two passages. The first is from the judgment of Lord Bridge:[213]

> This sweeping generalisation [that sterilization for a non-therapeutic purpose can *never* safely be determined to be in the best interests of a mentally incompetent person] seems to me, with respect, to be entirely unhelpful. To say that the court can never authorise sterilisation of

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[212] *Id.* at 219. See also his statements, *id.*, that:

> The primary and paramount question is only whether [the measures undertaken] are for the welfare and benefit of this particular young woman situate as she is situate in this case.
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> . . . . . .
>
> If in [the conclusion of La Forest J. in *Re Eve* that sterilisation should never be authorised for non-therapeutic purposes under the *parens patriae* jurisdiction] the expression "non-therapeutic" was intended to exclude measures taken for the necessary protection from future harm of the person over whom the jurisdiction is exercisable, then I respectfully dissent from it for it seems to me to contradict what is the sole and paramount criterion for the exercise of the jurisdiction, viz the welfare and benefit of the ward.

[213] *Id.* at 214.

> a ward as being in her best interests would be patently wrong. To say that it can only do so if the operation is "therapeutic" as opposed to "non-therapeutic" is to divert attention from the true issue, which is whether the operation is in the ward's best interest, and remove it to an area of arid semantic debate as to where the line is to be drawn between "therapeutic" and "non-therapeutic" treatment.

The second is from the judgment of Lord Oliver:[214]

> Something was sought to be made of the description of the operation for which authority was sought in *Re D* as "non-therapeutic" - using the word "therapeutic" as connoting the treatment of some malfunction or disease. The description was, no doubt, apt enough in that case, but I do not, for my part, find the distinction between "therapeutic" and "non-therapeutic" measures helpful in the context of the instant case, for it seems to me entirely immaterial whether measures undertaken for the protection against future and foreseeable injury are property described as "therapeutic".

4.100 Third, the right to reproduce is of value only if accompanied by the ability to make a choice. The judgment of Lord Bridge is instructive in this regard:[215]

> In *Re D (A Minor) (Wardship: Sterilisation)* [1976] Fam. 185, Heilbron J. correctly described the right of a woman to reproduce as a basic human right. The Canadian Supreme Court in *Re Eve* refer, equally aptly, to "the great privilege of giving birth". The sad fact in the instant case is that the mental and physical handicaps under which the ward suffers effectively render her incapable of ever exercising that right or enjoying the privilege. It is clear beyond argument that for her pregnancy would be an unmitigated disaster. The only question is how she may best be protected against it. The evidence proves overwhelmingly that the right answer is by a simple operation for occlusion of the fallopian tubes and that ... the operation should now be performed without further delay. I find it difficult to understand how anybody examining the facts humanely, compassionately and objectively could reach any other conclusion.

(4) The American Situation

4.101 In coming to the conclusion that superior courts do not have *parens patriae* jurisdiction to authorize sterilization for non-therapeutic purposes, the Supreme Court of Canada, in *Eve*, quoted liberally from the judgment in the American case of *Re Guardianship of Eberhardy*.[216] The case is one of a line of cases in which American state courts have held that, in the absence of the specific conferral of statutory power to make sterilization decisions, courts do not have jurisdiction to make non-therapeutic sterilization decisions.[217]

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[214] *Id.* at 219. *See also* n. 200, *supra*.

[215] *Supra* n. 4 at 214. *See also* Lord Hailsham at 213 and Lord Oliver at 219.

[216] *Supra* n. 174.

4.102 The impression could be left that *Re Guardianship of Eberhardy* articulates the American viewpoint. In fact the judgment reflects just one of three approaches to jurisdiction that have been taken by courts in the United States.

4.103 In a second line of cases, some state courts have found the jurisdiction to order non-therapeutic sterilizations to be an inherent part of the broad general jurisdiction conferred on superior courts by statute.[218] This source of authority was recognized by the United States Supreme Court in the case of *Stump* v. *Sparkman*,[219] which is mentioned in the judgment in *Re Eve*.[220] It has since been recognized in the judgments of some state courts.[221]

4.104 In a third line of cases, some state courts have found jurisdiction in the *parens patriae* power.[222]

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[217] *See e.g. Frazier* v. *Levi*, 440 S.W. 2d 393 (Tex. Civ. App. 1969); *Wade* v. *Bethesda Hospital*, 356 F. Supp. 380 (S.D. Ohio 1973); *Hudson* v. *Hudson*, 373 So. 2d 310 at 312 (Ala. 1979); *Re Guardianship of Eberhardy, supra* n. 174 at 898.

[218] Compare the jurisdiction conferred by Alberta's Judicature Act, R.S.A. 1980, c. J-1, s-ss. 5(1)(a) and (3)(b) and s. 7. *See* Appendix F, n. 20 and corresponding text.

[219] *Supra* n. 47 at 358.

[220] *Supra* n. 2 at 24.

[221] See *e.g. In Re Simpson*, 180 N.E. 2d 206 (1962 Ohio Prob.); *In Re Guardianship of Hayes*, 608 P 2d. 635 at 637-9 (Wash. S.C. 1980); *In Re Moe*, 432 N.E. 2d 712 at 715-719 (1982); *In Re A.W*, 637 P.2d 366 at 371-75 (1981); *Frazier* v. *Levi*, 440 S.W. 2d 393 (Tex. Civ. App. 1969); *Wade* v. *Bethesda Hospital*, 356 F. Supp. 380 (S.D. Ohio 1973).

[222] See *e.g. In Re Grady* 426 A. 2d 467 at 479-81 (N.J. S.C. 1981); *Wentzel* v. *Montgomery General Hospital*, 477 A. 2d 1244 at 1253 (Md. C.A. 1982); *In Re C.D.M*, 627 P. 2d 607 at 609-12 (Alaska S.C. 1981); *Cf. In Re Sellmaier*, 378 N.Y.S. 2d 989 (1976); *In Re Weberlist*, 360 N.Y.S. 2d 783 (1974); *Wyatt* v. *Aderholt*, 368 F. Supp. 1383 (M.D. Ala. 1974).

4.105 Short of legislation, the law is clear throughout the United States that, whatever the scope of jurisdiction of the court may be, a parent or guardian of a minor or mentally incompetent adult cannot consent to the performance of a sterilization for the purpose of contraception or menstrual management.[223]

4.106 The American situation is canvassed more fully in Appendix H.

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[223] *See* Appendix H, paras. H10 and H11.

CHAPTER 5: SHORTCOMINGS OF THE LAW

A. THE LEGACY OF *EVE*

(1) In General

5.1 There is no modern Canadian sterilization statute. Ontario has its age of consent for minors to a surgical operation in regulations under the Public Hospitals Act.[224] Alberta has its requirement of consultation by a second physician in regulations under the Hospitals Act.[225] Alberta and British Columbia once had eugenic sterilization statutes but they have been repealed.[226]

5.2 Given the general absence in Canada of legislation on sterilization, the judgment of the Supreme Court of Canada in *Re Eve* is of far-reaching effect.

5.3 The judgment has some useful features:

1. it underscores the seriousness of sterilization, being irreversible, as an intervention;

2. it settles the common law (the court has said, unanimously, that superior courts do not have *parens patriae* jurisdiction to authorize a non-therapeutic sterilization on behalf of a mentally incompetent person and, following from this, if courts cannot make the decision neither can parents or guardians);

3. it requires parents, guardians or others to bring questionable or "borderline" cases to court for decision; and

4. it specifies evidential and procedural standards to be followed in the cases that are brought to court.

5.4 However, the judgment has a number of shortcomings.

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[224] R.R.O. 1980, Reg. 865 s. 50 as am.

[225] The Operation of Approved Hospitals Regulation, Alta. Reg. 146/71 as am.

[226] S.A. 1928, c. 37, repealed S.A. 1972, c. 87; S.B.C. 1933, c. 59, repealed S.B.C. 1973, c. 79.

5.5 First, the limitation on the jurisdiction to consent to a non-therapeutic sterilization is a blanket one. The superior courts are denied the opportunity to consider individual cases on their own merits in order to determine whether a sterilization would be in the best interests of a mentally incompetent person notwithstanding that its purpose is non-therapeutic.

5.6 Second, the consequences are extreme. A parent or guardian can consent to a therapeutic sterilization. No one, not even a superior court, can consent to a non-therapeutic sterilization.

5.7 Third, the judgment gives little guidance on where the line between therapeutic and non-therapeutic sterilization lies.[227]

5.8 Fourth, the Supreme Court has taken a restrictive approach to the meaning of "best interests", having placed the preservation of the capacity to reproduce on a higher pedestal than other values and human needs. It has done so notwithstanding its admitted lack of knowledge about the attitudes, behaviours and perceptions of mentally disabled persons and about contraceptive methods, the alternatives to sterilization and their effects. Unless they contribute to a finding of "therapeutic", the Supreme Court has excluded the following interests from consideration on behalf of the mentally incompetent person: (i) avoiding the adverse side effects of long- or even short-term use of birth control pills or hormonal suppressants like Depo-provera; (ii) escaping the physical risks and pain of delivery; (iii) being spared the stress of parenting, the burden of children (e.g. family planning for a young woman who already has or has had one or more children,[228] or who is disinterested in children, loathes them or has shown physical abusiveness toward them); (iv) avoiding the sense of loss associated with the inevitable removal, by child welfare authorities, of an infant for whom the mentally incompetent parent may have the normal feelings of fondness and attachment; (v) maintaining the sense of accomplishment and satisfaction from sheltered workshop activity or club participation that would be jeopardized by pregnancy and child care responsibilities; (vi) facilitating the freedom to form relationships and experience sexuality without risking pregnancy or paternity; and (vii) contributing to the chance to lead a relatively free, minimally supervised life in the community.

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[227] In light of the subsequent rejection of the distinction by the House of Lords in *Re B*, courts in Canada may be persuaded to stretch the boundaries of therapeutic sterilization from the protection of physical or mental health to include social well-being in cases where it would be intellectually more honest to admit the benefit of sterilization for the primary purpose of contraception.

[228] Elizabeth S. Scott gives the example of a mentally incompetent woman with children who repeatedly insisted that she wanted "no more babies": "Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy" (1986) *Duke L.J.* 806 at 852, n. 149.

5.9 Fifth, the Supreme Court has made much of the "great privilege of giving birth", but it is silent about the scope of authority, if any, for the common practice of parents and guardians and courts to make birth control decisions on behalf of mentally incompetent persons.

5.10 Sixth, the placement of the line between mental competence and mental incompetence is not discussed in the judgment. Therefore, the judgment does not reveal whether a minor, however mature, could ever be competent to consent to sterilization for contraception or menstrual management.

5.11 Seventh, the judgment gives little help on the application of the Charter, saying essentially nothing more than that it would apply.[229]

(2) Effect in Alberta

(a) Minors

5.12 Alberta has no statute on the sterilization of minors. The *Eve* judgment therefore applies.

(b) Mentally Incompetent Adults

5.13 The Dependent Adults Act applies to mentally incompetent adults. As we stated previously,[230] a guardian appointed under the Act may be granted the authority to make health care decisions on behalf of the dependent adult. "Health care" is defined in the Act to include "any procedure undertaken for the purpose of preventing pregnancy".

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[229] According to the Supreme Court, section 7, which guarantees protection against laws or state actions that deprive persons of their liberty or security of person, does not oblige the court to act to prevent the deprivation of rights in the absence of governmental action. Section 15, which guarantees equality rights, does not oblige the court to make a choice between the right to procreate and the right not to procreate on behalf of a mentally incompetent person.

[230] *See supra* paras. 4.36-4.42.

5.14 The jurisdiction of the Surrogate Court and the guardians it appoints to make orders authorizing non-therapeutic sterilizations in the name of "health care" was debatable prior to the judgment of the Supreme Court of Canada in *Re Eve*. The *Eve* judgment strengthens the position of those who argue against the inclusion of non-therapeutic sterilizations in these words.

5.15 Two questions to ask are:

> (i) is the wording of the legislation sufficiently clear and unequivocal to authorize interference, for a non-therapeutic purpose, with the dependent adult's fundamental privilege of giving birth?
>
> (ii) are the procedures adequate to withstand the scrutiny of the courts under the Charter?

5.16 In answer to the first question, the better view appears to be no. First, the reference to the prevention of pregnancy must be read in the context of the full definition of "health care". The definition generally concerns examination, diagnosis and treatment for medical purposes. Non-therapeutic sterilization has another purpose. Second, decisions under the Dependent Adults Act are to be made in the individual's best interests. The legislation does not guide the court in making a determination about a non-therapeutic sterilization. The Surrogate Court is therefore placed in much the same position as a superior court exercising its *parens patriae* jurisdiction, and the Supreme Court has said that in this circumstance a non-therapeutic sterilization can never safely be determined to be in the best interests of a mentally incompetent person.

5.17 In answer to the second question, independent representation would have to be provided to satisfy the court that adequate precautions have been taken to prevent an erroneous decision. Independent representation is not a requirement under the Dependent Adults Act. It has not been common practice to provide it on applications for guardianship in general, nor the invariable practice on applications for advice and directions with respect to sterilization in particular. There is of course no legislative impediment to it being provided in cases of any sort.

5.18 In our opinion it is likely that the Dependent Adults Act does not confer jurisiction on the court to give consent to a non-therapeutic sterilization or to authorize a guardian to give it. If that is the case, there is no statute on the sterilization of mentally incompetent adults and the *Eve* judgment applies here as well.

B. THE NEED FOR REFORM

5.19 Prior to the *Eve* judgment, non-therapeutic sterilization was taking place on uncertain authority. There was fear in some quarters that abuses were occurring by reason of the intrusion.

5.20 The problem post-*Eve* is not that non-therapeutic sterilization will be performed too freely, but that there is a lack of authority to perform them at all. If the view taken of the limits of therapeutic sterilization is unduly restrictive, then a sterilization that is in the "best interests" of a mentally incompetent person may not be performed, to the detriment of the individual concerned.

5.21 We think, moreover, that the facts of *Re B* demonstrate the possibility that a sterilization may be in the "best interests" of a mentally incompetent person notwithstanding that it lies outside the therapeutic limit imposed by the Supreme Court of Canada. In our view the law should not add to the social disadvantages experienced by mentally incompetent persons by denying them the use, in a proper case, of the method of birth control most popularly chosen by persons in the general population. The denial would not be consonant with either the goal of normalization or the principle of equality.

5.22 Given the shortcomings of the *Eve* judgment, in our opinion, there is as great a need now as ever for legislation to safeguard and protect the interests of mentally incompetent persons.

CHAPTER 6: PRECEDENTS FOR REFORM

6.1 To give an indication of the solutions which could be adopted to meet the problems we have been discussing, we have provided brief descriptions of two Canadian proposals for a modern type of statute. The first proposal, described in Appendix I, is the one recommended in the Law Reform Commission of Canada's Working Paper 24 issued in 1979.[231] In addition to containing the Commission's tentative recommendations for reform of the law of sterilization, the Working Paper is an excellent source of information and we have used it liberally as a reference source.

6.2 The second proposal, described in Appendix J, comes from the Bill that was introduced in the Ontario Legislature in 1980.[232] The Ontario Bill dealt with consent to health care generally, but included specific provisions relating to consent to the sterilization of minors and mentally incompetent adults.

6.3 Although we have not adhered strictly to either one of them, both proposals have served as valued precedents and have given us substantial guidance. Both proposals provide for mental competence to consent to be determined by the court and sterilization decisions (excepting medical treatment) to be made by a specially constituted tribunal.[233] Both predate the determination in the *Eve* case.

6.4 These are just two of many proposals for legislation that have been made in recent years. They suggest, but in no way exhaust, the range of choice. The LRCC Working Paper outlines fourteen recent laws, proposals, or policy positions regarding sterilization procedures for the mentally disabled, and these are merely by way of example. They are drawn from Canadian and American jurisdictions and from New Zealand.[234]

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[231] *Supra* n. 12.

[232] *Supra* n. 6. The name of the Bill was "An Act respecting Consent to Health Care Services".

[233] We will recommend that both issues--mental incompetence and sterilization--should be decided by the court. Here we have parted company with the Law Reform Commission of Canada and the government that presented the Ontario Bill.

[234] *Supra* n. 12 at 85-104.

6.5 Several American states have legislation that extends to mentally disabled persons living in the community as well as to persons living in institutions. The modern statutes tend to emphasize the interests of the mentally incompetent person rather than the interests of others.[235] Some require the courts, tribunals or officials on whom jurisdiction is conferred to look at factors such as the ability of the mentally incompetent person to parent.

6.6 In formulating our recommendations for reform, we have been guided by the information contained in such studies and legislative provisions as well as by the recommendations of the Law Reform Commission of Canada and the contents of the Ontario Bill. We have also been guided by the opinions expressed in an abundance of periodical and other literature on the subject.

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[235] In this they are vastly different from the old eugenic Acts that were upheld by the United States Supreme Court in the case of *Buck* v. *Bell, supra* n. 39. Some of these Acts are still on the statute books.

CHAPTER 7: PRINCIPLES OF REFORM

7.1 We are persuaded of the need to reform the law to permit both therapeutic and non-therapeutic sterilization to be performed in appropriate cases. In formulating our recommendations we have followed four guiding principles:

- First, that if sterilization is to be permitted at all, it must be for the benefit of the person to be sterilized;
- second, that sterilization should be permitted only as a last resort, other alternatives having first been shown to be inadequate for the intended purpose;
- third, to the greatest extent possible the law relating to substitute sterilization decision making should respect the dignity, welfare and total development of the mentally disabled person for whom the sterilization is being considered; and
- fourth, that certain standards should be observed in the decision-making process to ensure the protection of the other principles.

A. BENEFIT TO THE PERSON TO BE STERILIZED

(1) The Principle

7.2 Our first guiding principle is that if sterilization is to be permitted at all, it must be for the benefit of the person to be sterilized. This is the principle that underlies the exercise of the *parens patriae* jurisdiction. Our reasons for adopting it are explained as follows: (i) sterilization deprives a person of the privilege of giving birth (sometimes characterized as a fundamental or basic human right)[236]; (ii) the procedure is, for all practical purposes, irreversible; (iii) it is physically intrusive and may have adverse consequences psychologically; and (iv) therefore, a sterilization should not be undertaken on the strength of a substitute consent except in compelling circumstances.

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[236] *Re B, supra* n. 4 at 215 per Lord Templeman; *Re D, supra* n. 200 at 332.

(2) Application of the Principle

(a) Sterilization for Medical Treatment

7.3 Sterilization for medical treatment fits well within this principle. Medical treatment is beneficial by definition and sterilization for medical treatment should therefore be permitted. That is not to say that it will invariably be in the best interests of a person to receive a proposed treatment. Occasionally, the risks of the treatment will outweigh its benefit to a given individual. The full circumstances may need to be carefully assessed.

(b) Sterilization for Contraception

7.4 Sterilization for contraception presents more difficult considerations. We are persuaded by the argument that there could be cases where a mentally incompetent person may experience benefits from a sterilization for contraception similar to those experienced by persons in the normal population. She may be spared the burden of caring for offspring when she lacks parenting skills, the financial resources to raise them[237] or the inclination to have them. If the risk of deformity in her offspring is high she may be spared the strain of the additional parenting and financial demands associated with raising a disabled child. She may be spared and wish to be spared the heartache of having her child removed from her because of her inadequate parenting ability. She may desire to live a freer, less encumbered sexual life. Although because of her mental incompetence at law to make the decision, it must be made by another on her behalf, it is nevertheless arguable that it would be wrong to deprive her of access to a means of contraception that is increasingly the birth control method of personal choice for others in society.

7.5 We have concluded that, consistent with the normalization principle, sterilization for contraception should be available as a possibility for a mentally incompetent person, on appropriate facts.

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[237] Sterilizing a mentally incompetent person because of the economic burden alone seems drastic but financial matters are a legitimate consideration for a mentally competent person and there may well be cases where it is equally appropriate to protect a mentally incompetent person from the added financial costs of children. Indeed, the Law Reform Commission of Canada has pointed out that "[t]he additional financial burden of children on top of already existing economic problems may become the triggering factor for other psychological or emotional adjustment problems and may impair the ability to cope": *supra* n. 12 at 34.

(c) Hysterectomy for Menstrual Management

7.6 Hysterectomy for menstrual management presents even more difficult considerations. Prior to the *Eve* case, there was some difference of opinion about whether the performance of a hysterectomy for menstrual management is or may be therapeutic. Some physicians took the view that it constituted therapy. Associations for the mentally retarded took the view that it did not. The Canada Law Reform Commission expressed doubt that it was therapy.[238] A noted Canadian scholar observed that "hygienic reasons are classified as non-therapeutic lest retarded girls be sterilized upon mere grounds of institutional inconvenience in managing their menstruation".[239] An Australian text on Mental Retardation stated:[240]

> Hygienic "reasons" for sterilization appear to reflect the medical profession's inadequate knowledge or training in social and self-help skills for retarded people, as well as a general coyness about menstruation. No reasonable medical practitioner would undertake an operation for colostomy because the patient smeared faeces around the house - why is the smearing of menstrual blood considered so much more abhorrent and untreatable by education, conditioning and behaviour modification techniques? The application of the principle of the least restrictive alternative seems tragically ignored in the area of sterilization.

The Supreme Court of Canada put these differences to rest in *Re Eve* when it said that hysterectomy is excessive for the purpose.

7.7 It is arguable that the elimination of menses would be of benefit to the minor or mentally incompetent adult in some cases. One argument relates to a case where a mentally disabled woman's integration into the community would be facilitated by removing the burden of managing menstruation because it cannot be suitably handled. Another argument relates to the effect on the mentally incompetent female of the additional stress that would be borne by family or other private caregivers if the hysterectomy were not performed. It recognizes the limits of endurance of family members who choose to look after a mentally disabled female at home, for her benefit, despite enormous strain and burden on the family. In the British Columbia case of *Re K*, one judge in the

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[238] *Id.* at 34.

[239] Bernard M. Dickens, *supra* n. 17 at 270.

[240] Susan C. Hayes and Robert Hayes, *Mental Retardation: Law, Policy and Administration* (1982) at 80.

Court of Appeal[241] referred to the risk that K would have to be placed in institutional care if, when added to the other burdens, the burden of menstrual management was too much for her family. He stated:[242]

> While the parents dealt with the problems of caring for Infant K in an exemplary fashion there was, in my opinion, a risk that the additional burdens caused by the onset of menstruation would be too much for them. If this risk became a reality, Infant K would suffer. The standard of care might be affected to the detriment of Infant K or it might be that she would have to be placed in an institution. All interested parties agreed that it was better for Infant K to live at home with her parents than in an institution. Love and affection as exemplified by the conduct of these parents was all important. Such love and affection could not be given in an institutional setting.

7.8 The normalization argument is not as persuasive here because hysterectomy for menstrual management is not a common choice of mentally competent women. This observation notwithstanding, the choice theoretically would be open to a mentally competent woman who did not want to bear children and who preferred to be relieved of the monthly chore of tending to menstrual discharges. One can envisage circumstances in which menstrual management would present a particular burden to a mentally incompetent woman. We therefore think that the possibility of hysterectomy for menstrual management should be available to permanently mentally incompetent females, on appropriate facts.

(d) Rejection of Interests of Others

7.9 The interests of others fall into three groups: the interests of prospective offspring, the interests of the family or other persons giving primary care and the interests of society in general. We have concluded that none of these interests is sufficiently compelling to take into consideration, except insofar as they affect the interests of the person to be sterilized. We will nevertheless set out some arguments that may be made in support of considering the interests of others.[243]

7.10 First, as to the benefit to prospective offspring. It would be possible to give separate consideration to the interests of the as yet unconceived, unborn children of the person involved. It may be argued that it is wrong to allow a child to be born to a parent who will not be able to care for him properly. It may be thought, for example, that a child who is unable to be raised by his or her parents begins life at a serious disadvantage. Or, it may be thought that a mentally incompetent person would be unable to provide a normal child with adequate stimulation and that the child would thereby be deprived. The risk of deformity in prospective offspring is another factor which may be taken into account. Here it may be argued that it is wrong to allow a child to be born when it is known that there is a serious risk that the child will be born with genetic defects or other severe deformities. The arguments regarding proper care for the child and the risk of deformity are both ones that a mentally competent adult may consider in deciding to undergo a sterilization for contraception.

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[241] Anderson J.

[242] *Supra* n. 16 at 751.

[243] Most of these arguments are taken from the Law Reform Commission of Canada Working Paper 24, *supra* n. 12 at 24-31.

7.11 Second, as to the benefit to caregivers. A sterilization for contraception may be argued to relieve the burden on the family or other private caregivers. The argument assumes that the responsibility of supervising sexual activity and birth control, providing the added care needed during pregnancy and assisting with the care of a child born to the mentally incompetent person may be stressful to the persons looking after the mentally incompetent person. Psychological factors such as embarrassment or humiliation may exacerbate that stress. An hysterectomy for menstrual management may also be argued to ease the burden on caregivers. The argument assumes that the inability of a mentally disabled female to look after her menstrual discharges may cause embarrassment, aggravation and distress to the persons looking after her.[244] The relief of the burden on caregivers is not an argument that is likely to be present in the case of a decision by a mentally competent adult.

7.12 Third, as to the benefit to society in general. It is sometimes argued that mentally incompetent persons will not be able to provide for children financially and will not be able to give children proper parental care, to the detriment not only of the children but also of the larger society because it will have to make provision for rearing the children. The argument may be advanced whether or not the prospective children are likely to be able to support themselves after they reach maturity. It is more likely, however, to assume that the prospective children of the minor or mentally incompetent adult will themselves be charges on society. The effect on society of one's ability to make financial provision for and to raise one's children is not likely to be a factor in the sterilization decision of a mentally competent adult.

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[244] Sympathy for this argument was expressed by the trial judge in the Saskatchewan case of *Bell* v. *Society for the Promotion of Education and Activities for Children in the Home*, *supra* n. 154.

7.13 Consideration of all of these other interests is, as we said above, excluded by our first principle.

B. STERILIZATION AS A LAST RESORT

7.14 Our second guiding principle is that sterilization should be permitted only as a last resort;[245] other alternatives should first be shown to be inadequate for the intended purpose.

7.15 In adopting this principle, we have borrowed from a constitutional doctrine developed by American courts. The doctrine relates to state interventions in private lives to promote a state interest. It is that the "least restrictive alternative" or "least drastic means" available should be used to achieve the state goal.

7.16 This doctrine was developed in the context of civil commitment (i.e. involuntary hospitalization for mental disorder). It is founded in the notion that people should be free to live as they please unless they are harming others. When others in society have a legitimate interest to be met, the state should act through means that curtail individual freedom to no greater extent than is essential for securing the goal. The concept is evidenced in two Alberta statutes: the Dependent Adults Act and the Child Welfare Act. The underlying goal in both of these cases is the protection of the individual.

7.17 The doctrine could be usefully applied to substitute sterilization decision making. It would work this way: given that the use of a method of birth control is justified, it should be achieved by the least intrusive or restrictive alternative intervention capable of satisfying the interests to be met in the particular circumstances of this mentally incompetent person. Reversible methods of contraception would be used before irreversible methods. Training to use other contraceptive methods would be provided where it could reasonably reduce the need for a measure as severe as a surgical operation. Where a sterilization is required, the least drastic form of surgery would be used. An hysterectomy would not be performed for contraception alone in the absence of other indications.

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[245] *Re B, supra* n. 4 at 218-9 per Lord Oliver.

7.18 Three criteria have been suggested for applying the principle, again in the context of civil commitment.[246] The three criteria are: intrusiveness, harshness and hazardousness.

7.19 An "intrusive" technique is drastic in that it has an obvious impact on mental and bodily privacy, comfort, safety and well-being. Factors for measuring the extent of the intrusiveness include: the extent to which the method or procedure is reversible; the extent to which the resulting state is 'foreign', 'abnormal' or 'unnatural'; the rapidity with which the effects occur (the swifter the change the more intrusive); the scope of change in the total 'ecology' of the person (embracing psychological and spiritual as well as physical effects); and the duration of the change. Hysterectomy is the most intrusive means of contraception.

7.20 "Harshness" refers to the actual or potential discomfort that is an integral, purposeful step in the method or procedure. It includes such distasteful aspects as the infliction of great pain or physical harm, deprivation of basic comforts and convenience and inducement of fear or unpleasant physical reactions such as vomiting. The labour contractions of induced abortion provide an example.

7.21 "Hazardousness" refers to the undesigned consequences of the method or procedure, that is, the risks of something going wrong. Examples are the side effects produced by the estrogen component of "the pill", bleeding caused by abortion and risk of morbidity.

C. RESPECT FOR PERSONAL DIGNITY

7.22 Our third guiding principle is that, to the greatest extent possible, the law relating to substitute sterilization decision making should respect the dignity, welfare and total development of the mentally disabled person for whom sterilization is being considered.

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[246] Special Article Series on "Legal Issues in State Mental Health Care: Proposals for Change: Civil Commitment" (1977) 73 *Mental Disability Law Reporter* 115-7; *and see* Shapiro, "Legislating the Control of Behavior Control: Autonomy and Coercive Use of Organic Therapies" (1974) 47 *S. Cal. L. Rev.* 237 quoted therein.

7.23 One proposition flowing from this principle is that the law should state with a reasonable degree of precision and comprehensibility what is meant by incompetence or disability in this context. A second proposition is that a person whose mental incompetence is not likely to be permanent should not be deprived of the right to make a personal choice with regard to the privilege of giving birth. (Medical treatment would be an exception.) A third proposition is that the substitute decision should be attended by appropriate substantive and procedural safeguards and that the decision-making process should not be demeaning or degrading.

D. CHARACTERISTICS OF THE DECISION-MAKING PROCESS

7.24 Our fourth guiding principle is that, as far as is reasonably possible, the decision-making process should have the following characteristics: (i) the decision maker should be easily accessible; (ii) the procedure should be non-disruptive of the lives of the mentally disabled person and her family; (iii) the decision maker should have access to all relevant evidence; (iv) there should be a full hearing of persons having relevant information; and (v) the decision should be made in as objective a manner as is humanly possible.

CHAPTER 8: CHOICE OF DECISION MAKER

A. IMPORTANCE OF CHOICE

8.1 The choice of decision maker is a fundamental one as the Law Reform Commission of Canada has pointed out:[247]

> ... allocation of the decision-making power may in itself determine the kinds of decisions made unless public policy has been clearly outlined and it has been determined whether exceptions to it are morally and socially tolerable.

In our view, the decision maker should be the one best able to satisfy the requirements of our four principles of the decision-making process set out in Chapter 7.

B. POSSIBLE DECISION MAKERS

8.2 We considered decision makers in five categories: (i) a physician; (ii) a parent or private guardian; (iii) the Children's Guardian or Public Guardian; (iv) a special tribunal; or (v) a court. In the fifth category, we looked at three possibilities: the Court of Queen's Bench, the Surrogate Court or the Provincial Court (Family Division).

(1) Physician

8.3 The physician comes to mind for several reasons. First, the physician is needed to perform the sterilization, so he will invariably be present. Second, the physician's code of ethics requires him to do what is medically best for the patient. Third, in order to avoid liability in battery for performing the operation, it is the physician who must be satisfied either that the patient's consent is competently given or that other valid authority to sterilize exists. As an added safeguard the physician could be required to obtain the concurring opinion of a second physician that the person is mentally incompetent, the sterilization would be in the person's best interests and the surgical method proposed is the least intrusive for the purpose.[248]

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[247] *Supra* n. 12.

[248] Compare Alta. Reg. 146/71, *supra* n. 225.

8.4 On the other hand, physicians are not ordinarily endowed with the power to make decisions for their patients. They are permitted to proceed without the consent of the patient or a person on his behalf only in exceptional circumstances, such as an emergency. Moreover, the decision to perform a sterilization for contraception or a hysterectomy for menstrual management falls outside the usual realm of clinical judgment for the purpose of medical treatment. Far from being strictly medical, the decision is largely cultural and psycho-social in orientation.

(2) Parent, Private Guardian or Other Private Person Responsible for Care

8.5 It can be argued that the decision to perform a sterilization on a person who is unable to make a personal decision should be left to the family, if there is one, because the family is the natural protector of its children and mentally disabled members. The general rule under the existing law is that the consent of a parent or guardian, in the case of a minor, or of a guardian with authority to consent to health care, in the case of a mentally incompetent adult, is sufficient to authorize medical treatment. That rule could be extended to cover sterilization for other purposes as well.

8.6 Those who espouse the view that the decision is essentially a private matter for the family argue that the family best knows the situation and needs of the mentally disabled person. Leaving the decision to the family therefore preserves and respects private decision making and family stability.[249]

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[249] Figures maintained by the Public Guardian indicate that in the majority of cases the guardian is a family member or close friend. Only 23% of dependent adults are under Public Guardianship (interview with Assistant Public Guardian July 1986). It is noteworthy that family privacy receives fundamental protection under the European Convention of Human Rights and Freedoms, a document which provided the precedent for some sections of the Canadian Charter. Article 8 of the Convention provides:

> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

8.7 Those who believe there is an issue which needs to be aired beyond the family point out that a parent, private guardian or other private person bearing the responsibility for care is unlikely to have expertise in assessing mental abilities and applying the legal test of competence. Where the purpose of the proposed sterilization is contraception or menstrual management the subjectivity that comes from close personal involvement may operate to the detriment rather than benefit of the mentally incompetent person. For example, the decision maker may wish the operation to take place for his own or family convenience - to avoid being burdened by the care of a child born to the mentally incompetent person or to avoid having to cope with the problem of menstrual management. He may have a tendency to overprotect the mentally disabled person rather than to let her experiment with success and failure in relationships and the expression of sexuality. He may be moved by concern for the family name. He may be talked into consenting to satisfy an institutional policy demanding sterilization for placement of persons in the institution.

8.8 One writer puts it this way for parent and child:[250]

> The possibility of conflicting interests between parent and child raises doubt that the parent is acting solely in the child's best interest. Diminished worry, convenience, a wish to be relieved of responsibility for close supervision, and inability to deal with a difficult problem may cause even the most well-intentioned parent or guardian to act against the retarded's best interest. The choice of the parent or guardian cannot remain unfettered, so the court must consent on behalf of the incompetent. (Footnotes omitted.)

(3) Children's Guardian or Public Guardian

8.9 The arguments based on personal involvement do not apply as strongly to a guardian who is not a family member or friend, for example, the Children's Guardian or, in the case of a dependent adult, the Public Guardian. Some provision would have to be made in any event for cases in which there is no family member or other private person in a position to decide. Moreover, not all mentally incompetent persons live with parents or guardians. Many live in institutions.

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[250] C. Struble, "Protection of the Mentally Retarded Individual's Right to Choose Sterilization: the Effect of the Clear and Convincing Evidence Standard" (1983) 12 *Capital U.L.R.* 413 at 418.

8.10 There is, however, no assurance that a public official would be any better equipped to determine competence than a private person, or to gather all of the information that should be considered and make an unbiased decision about a sterilization.

(4) Special Tribunal

8.11 Another alternative would be to have the critical decisions made by a specially designated tribunal. This alternative would afford the person at risk of bodily violation and loss of the capacity to have children the protection of a decision by an impartial external decision maker after a full hearing of the issues. Legislation conferring guardianship jurisdiction on a provincially established court has been judicially upheld.[251] We therefore do not anticipate any constitutional obstacle to the legislative conferral of jurisdiction to make sterilization decisions on a provincially constituted tribunal.

8.12 The alternative of a special tribunal presents some degree of procedural flexibility. The proceedings could be specially designed. For example, they might be structured so as to take into account the seriousness of the issue to be decided, but nevertheless informal so as to encourage the full and thoughtful participation in the hearing of family members, expert consultants, and any other interested person having relevant information. The hearing would not need to be adversarial in tone; it could instead be a hearing in the nature of an inquiry. It could be held at a location convenient to the participants, for example, at a local hospital or the institution where the mentally disabled person resides. The tribunal could be composed of persons selected because of their particular mix of backgrounds, e.g. lawyers, physicians, psychologists, theologians, social workers, parents of mentally disabled persons. The cost to the participants could be kept down.

8.13 The arguments for and against a special tribunal depend to some extent on the issue or issues it is asked to determine and, in the case of the decision about a sterilization for contraception or a hysterectomy for menstrual management, the nature of the criteria to be applied. The desirable qualifications of a body charged with deciding whether or not a person is mentally competent to consent to a sterilization may be different from those of a body charged with deciding whether or not a person is capable of providing financial support to prospective children. This, in turn, may be different from the desirable qualifications of a body charged with deciding whether or not a person is capable of functioning as a parent in other ways.

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[251] *Reference re s. 6 of Family Relations Act, 1978; A.G. (Ont.)* v. *A.G. (Can.)* [1982] 3 W.W.R. 1 (S.C.C.).

8.14 The question of mental incompetence, for example, may best be determined by a special tribunal composed of a mix of psychiatric, psychological and legal experts. The decision to perform a sterilization for contraception or a hysterectomy for menstrual management, on the other hand, may best be made by a special tribunal consisting of some members with qualifications in social areas and other members with medical qualifications. The method of sterilization may be viewed as an essentially medical question best decided by a special tribunal composed of medical experts.

8.15 Decisions would have to be made about who would appoint the members and where they would come from. Getting the committee members together, and therefore accessibility, could be a problem. There would be administrative costs including such items as the remuneration of members and their travel and accommodation expenses for hearings held around the province.

(5) Court

8.16 The last alternative is a court. As was true of a special tribunal, this alternative would afford the person whose sterilization is sought the protection of a decision by an impartial external decision maker after a full hearing of the issues.

8.17 We considered three possible courts: the Court of Queen's Bench, the Surrogate Court or the Family Division of the Provincial Court. The Court of Queen's Bench, Alberta's highest court of first instance, is a superior court having plenary jurisdiction including *parens patriae* jurisdiction to protect persons who are unable to make decisions for themselves. This is a feature that could be significant if the decision about competence to consent to sterilization is only one aspect of the larger question of competence to perform other legal acts and manage one's person and affairs. Moreover, requiring sterilization decisions to be made by a court at this level emphasizes the gravity of the decision being taken.

8.18 The Surrogate Court is the court named under the Dependent Adults Act.[252] It is constituted of judges of the Court of Queen's Bench[253] but its jurisdiction is limited to "testamentary matters and causes"[254] and all matters relating to guardianship of the person.[255] It does not enjoy general jurisdiction over adults or children. For the authorized purposes it "has the same powers, jurisdiction and authority" as the Court of Queen's Bench and its judges.[256] There is power for a judge to remove a proper case to the Court of Queen's Bench but the power appears to be restricted to property matters involving an amount of over $3500.[257]

8.19 The Family Division of the Provincial Court is established by Alberta's Provincial Court Act.[258] The Family Division exercises jurisdiction over many family law matters, including the maintenance of family members and custody of children. The judges of this Court are therefore accustomed to dealing with issues of significance to the lives of individuals in the family context. The Court is readily accessible. The proceedings before it are less formal than proceedings before taken the Court of Queen's Bench or the Surrogate Court, and less costly to the litigant. It may therefore be less foreboding to the general public than the Surrogate Court or Court of Queen's Bench. The Family Division, like the Surrogate Court, has the disadvantage that it does not enjoy plenary jurisdiction over issues of competence and the protection of individual civil rights.

8.20 As for a tribunal, the arguments for and against a court will vary somewhat depending on the issue the court is being asked to determine. The main advantage of the court is that it is the most independent and impartial tribunal available. It is already in existence and has public credibility. Judges are accustomed to determining competence and to dealing with difficult issues concerning the exercise of individual civil rights. Judges are also accustomed to providing the persons who should be heard with an opportunity to be heard. Courts have the power to compel evidence and a process that permits consideration of a range of expertise. Reasons for court decisions are published. Keying into a court system that already exists could save some administrative costs.

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[252] *Supra* n. 102, s. 1(c).

[253] Surrogate Court Act, R.S.A. 1980, c. S-28, s. 1(g).

[254] *Id.* s. 3.

[255] *Id.* ss. 9 and 10(1).

[256] *Id.* s. 10(1).

[257] *Id.* s. 17(1).

[258] R.S.A. 1980, c. P-20.

8.21 The greatest disadvantage of the court may be the cost of the proceedings to the participants. A simple application is likely to cost several hundred dollars, a difficult one several hundred dollars more. For many people this would be an impossible financial burden. The formality of the court process may also be daunting to many parents and guardians and discourage them from seeking sterilization where it would benefit the mentally incompetent person. An adversarial process may detract from the dignity and worth of the individual. Furthermore, as the Supreme Court of Canada has told us, judges are not expert in the field of sterilization decision making.

C. CONCLUSION

(1) A Private or Public Matter?

8.22 We have set out arguments that favour a decision by a parent, private guardian or other private person responsible for the care of the mentally disabled person. We have also set out arguments that favour a decision by an impartial external decision maker. The comparative quality of decisions made by the family or an external decision maker such as a court or tribunal is difficult, if not impossible, to assess. The question whether the decision should be a private matter for the family or a matter requiring the intervention of an independent outsider is nevertheless an important one to ask. The perception one has of the problem obviously colours one's views of the reform measures that are needed.

(2) One Decision Maker or Two?

8.23 Another issue affecting the choice of decision maker is whether different decisions require different decision makers. Should one decision maker make the finding of mental incompetence, determine the appropriateness of sterilization in the circumstances of the case and choose the method by which the sterilization is to be performed, or should the decision makers be different?

8.24 The Law Reform Commission of Canada, in its Working Paper, and the government of Ontario, in the Bill introduced in the Ontario Legislature in 1980, each proposed two decision makers: the Court for competence and a special tribunal for sterilization.[159]

8.25 There are advantages both ways. On the one hand, there may be less procedural disruption to the mentally disabled person and his family if all of the matters in question are decided in one proceeding. As well, having the whole case before it may help the decision maker with its decision about competence. Competence is not something abstract; it is instead bound up with the facts which go to best interests, what the mentally disabled person has done (his functional ability) and so on. On the other hand, the decision-making roles may vary such that some decisions may be more appropriate to one decision maker, others to another decision maker.

(3) Our Choice

8.26 Our application of the principles identified in Chapter 7, and in particular of the characteristics embodied in the fourth principle, has led us to recommend that the Court of Queen's Bench should be responsible for all of the decisions. We see an advantage in the fact that it is a superior court having plenary jurisdiction over issues of competence and the protection of the individual. The caution exhibited by the Supreme Court of Canada in the *Eve* case has caused us to think that both courts and legislators are likely to regard the issue as too important to be left to any decision maker other than a superior court.

8.27 In forming our opinion, we have been influenced by the words of Lord Templeman in his judgment in the case of *Re B*. He says:[160]

> In my opinion sterilization of a girl under 18 should only be carried out with the leave of a High Court judge ... A court exercising the wardship jurisdiction emanating from the Crown is the only authority which is empowered to authorise such a drastic step as sterilisation after a full and informed investigation. The girl will be represented by the Official Solicitor or some other appropriate guardian; the parents will be made parties if they wish to appear and where appropriate the local authority will also appear. Expert evidence will be adduced setting out the reasons for the application, the history, conditions, circumstances and foreseeable future of the girl, the risks and consequences of pregnancy, the risks and

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[159] *See supra* paras. 6.1-6.3.

[160] *Supra* n. 4 at 214-15.

consequences of sterilisation, the practicability of alternative precautions against pregnancy and any other relevant information. The judge may order additional evidence to be obtained. In my opinion, a decision should only be made by a High Court judge. ... No one has suggested a more satisfactory tribunal or a more satisfactory method of reaching a decision which vitally concerns an individual but also involves principles of law, ethics and medical practice.

CHAPTER 9: TENTATIVE RECOMMENDATIONS FOR REFORM

9.1 In the text of this chapter we present our tentative recommendations for reform. The recommendations are set out following the chapter, in Part III.

A. RECOMMENDATION FOR LEGISLATION

9.2 We concluded, in Chapter 5, that there is a sound case for legislation to govern sterilization decisions. Accordingly we recommend that such legislation be enacted.

B. PERSONS AFFECTED BY THE LEGISLATION

(1) Adults

9.3 We can see no reason why a sterilization for any purpose should not be performed on an adult person who is competent to give an informed consent and who without compulsion does so. We would therefore confine the scope of the proposed legislation to mentally incompetent adults.

(2) Minors

9.4 Most minors will not be mentally competent to consent to either medical treatment or sterilization. Our recommended legislation would therefore apply to them.

9.5 The law, however, recognizes as valid the consent to medical treatment of a minor who is sufficiently mature to give it. In this way the law takes into account the fact that some older minors leave home and assume responsibility for their own decisions and the fact that others living at home have the capacity to make their own decisions.

9.6 Should the law also recognize as valid the consent of a mature minor to sterilization? One alternative would be to recognize the validity of the consent of a mature minor to sterilization for any purpose, as in the case of a mentally competent adult. A second alternative would be to legislate that all minors are incapable of consenting to sterilization. The argument in favour of this alternative is that (i) the power of procreation is a valuable one, (ii) young persons do not have sufficient maturity to foresee the long-term implications of its irreversible removal, and (iii) therefore, except where the sterilization is necessary for medical treatment, the sterilization of a minor on her own consent is not justifiable. A third alternative would be to permit mature minors to consent to sterilizations for some purposes but not for other purposes.

9.7 We have chosen the third alternative. We give effect to this choice in the recommendation we will make to except a sterilization for necessary medical treatment from the ambit of the proposed legislation.[261] In recommending this exception, we depart from the recommendation we made in our Report No. 19 on Consent of Minors to Health Care that a minor should not be able to give consent to a sterilization for any purpose.[262] We now think that the category we have carved out for necessary medical treatment, compared with medical treatment in general, is sufficiently definitive to justify permitting a minor who understands the nature and consequences of a sterilization for this purpose to consent to it. Our position on consent to sterilization for other purposes remains unchanged.

9.8 One further point is that the functional level of performance that a minor is capable of achieving is difficult to predict. Some would argue that, subject to the exception for necessary medical treatment, sterilization of minors should be prohibited on any authority. The prohibition would give a minor suffering from mental retardation or other mental disability an opportunity equal to that enjoyed by other minors to mature. This would allow for a more accurate determination of the likelihood that the mental incompetence is the product of mental disability and *not* immaturity of years. We do not recommend the adoption of this position but note it for consideration.

C. DEFINITION OF COMPETENCE

9.9 To be competent to consent to medical treatment, the patient must be able to understand and appreciate the nature of the medical procedure proposed and the attendant risks. We recommend that the test of competence to consent to sterilization should be framed in similar language. Where a sterilization for medical treatment or contraception is proposed, the person should be able to understand and appreciate the nature and consequences of reproduction, the nature and consequences of sterilization including the fact that loss of the ability to produce children is likely to or will be permanent, and the consequences of giving or withholding consent. Where a hysterectomy for menstrual management is proposed, she should also be able to understand and appreciate the nature and consequences of the proposed hysterectomy, including the fact that the loss of the uterus will render her permanently incapable of becoming pregnant.

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[261] *See infra* para. 9.19.

[262] *Supra* n. 101 at 30.

D. DEFINITION OF STERILIZATION

9.10 Without using the word "sterilization", the Ontario bill describes "a surgical operation or medical procedure that will render a person permanently incapable of natural insemination or of becoming pregnant". This definition was developed to cover all procedures having a sterilizing effect. Our recommendation is based on it.

E. SCOPE OF LEGISLATION

(1) Recap of Sterilization Purposes

9.11 In the earlier chapters of this report we have spoken of sterilization for the diverse purposes of medical treatment, contraception and menstrual management. We have also observed that the same medical procedures may be used to achieve one or more of these purposes. We concluded in Chapter 7[263] and now recommend that sterilization for each of these purposes should be available as a possiblity for a mentally incompetent person on appropriate facts.

(2) Recommended Legislation

9.12 For a decision by a competent adult with respect to her own body, distinctions in purpose of sterilization are essentially academic. Provided that a physician is willing to perform the procedure, the authority to decide lies with the patient no matter how the sterilization is classified.

9.13 For minors and mentally incompetent adults, it is necessary to determine whether the legislation will govern all sterilizations or whether some sterilizations will fall outside it. It is further necessary to determine whether different provisions should apply to sterilization for different purposes. For example, should a sterilization for medical treatment be subject to the same provisions as a sterilization for menstrual management? If differences in the applicable provisions are recommended, then the distinctions in purpose become important.

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[263] *See supra* paras. 7.3-7.8.

(a) Exception of Sterilization for Necessary Medical Treatment

9.14 In our view, minors and mentally incompetent adults should receive a wide degree of protection from the performance of unwarranted sterilization. We would therefore apply our recommended legislation broadly. However, we would not want our recommendations to have the effect of delaying the access of minors and mentally incompetent adults to sterilization for medical treatment that it is in their best interests to receive, or of burdening them with a court application that, if not brought, would deprive them of a necessary sterilization.

9.15 But where should the line delimiting sterilization for medical treatment be drawn? Under the existing law, its placement is unclear. Prior to final judgment in the case of *Re Eve*, the position of the line tended to vary with the definition of health care used by the medical practitioner consulted, with one physician calling a procedure "medical treatment" only if it is carried out to avoid risk to life or critical physical health, another including psychological or emotional risk, and still another including social factors which have the potential to affect the well-being of the person as a whole. In the *Eve* case, the Supreme Court of Canada drew the line at sterilization undertaken for the protection of the physical or mental health of the person to be sterilized. Even within the bounds of this decision, some medical treatment may be necessary whereas other medical treatment may be optional.

9.16 The Law Reform Commission of Canada and the Ontario government responsible for introducing the Ontario bill have both considered the issue of line drawing in legislation. The Law Reform Commission of Canada would except some sterilizing procedures from legislation. The exception would encompass "any procedure carried out for the purpose of ameliorating, remedying, or lessening the effect of disease, illness, disability, or disorder of the genito-urinary system."[344] If the words "disease, illness, disability or disorder" are read disjunctively, this exception could include a sterilization undertaken for the protection of mental as well as physical health. If they all describe the "genito-urinary system", it would not. The Ontario government would also have excepted some sterilizing procedures from the Ontario bill. The exception would have been for a sterilization that "is medically necessary for the protection of the physical health of the person".[265]

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[344] LRCC WP 24, *supra* n. 12 at 106.

9.17 We see two advantages in restricting the exception to physical health. The first advantage is that the exception would be likely to guide families or other interested persons and physicians to the right decision-making procedure. That is because it is worded to circumvent the conceptually grey area between sterilization undertaken for the protection of mental health and sterilization undertaken for contraception. The second advantage is that the exception would, we think, discourage persons from employing the authority to consent to medical treatment to authorize a sterilization for another purpose in avoidance of the legislated safeguards. That is because it is narrowly described.

9.18 Our recommendation is that sterilization for necessary medical treatment should be excepted from the proposed legislation. Necessary medical treatment should be defined in the language of the Ontario bill as treatment that is medically necessary for the protection of physical health. The exception would include a sterilization to remove a diseased organ, and the sterilization of a sexually active, fertile woman with a disease (e.g., active tuberculosis, or severe heart, kidney or circulatory disease) that makes pregnancy dangerous to her physical health. The determination of the medical necessity of the sterilization would involve the weighing of factors such as the immediacy of the risk (i.e., urgency, which may be less dire than emergency) posed by the clinically diagnosed condition, and the inevitability of the risk posed (e.g. the condition is life-threatening or, if unchecked, will lead to serious irreversible physical damage).

9.19 The result of our recommendation is that a sterilization for necessary medical treatment would be governed by the existing law of medical consent. Under that law, where a person is a minor and mentally competent to do so she would be able to make her own decision in this regard.[266] Where she is a minor and mentally incompetent, her parent or guardian would be able to give the consent by exercising the usual authority to make medical treatment decisions for a minor. Where the person is a mentally incompetent adult with a guardian who has authority to make health care decisions, the guardian would be able to consent to the sterilization for necessary medical treatment. Where she is a mentally incompetent adult without a guardian, the necessary medical treatment could be given on the strength of the certificates of two physicians under section 20.1 of the Dependent Adults Act. In a case of doubt an order of a superior court, granted in the exercise of its *parens patriae* jurisdiction, could be sought. In an emergency no consent would be needed.

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[265] *Supra* n. 6, s. 15.

[266] *See supra* para. 9.7.

(b) Elective Sterilization

(i) Optional Medical Treatment

9.20 Where the medical treatment is optional, in contrast with necessary, the authority to perform a sterilization would be obtained under the proposed legislation. Sterilization for optional medical treatment would include sterilization to remedy a condition that does not immediately or inevitably seriously threaten physical health. It would also include sterilization to remedy a condition that threatens mental health. This classification would encompass sterilization in a situation where a further pregnancy would increase the probability of serious complication with subsequent births (e.g., a series of prior births by Caesarian section); a congenital or hereditary disease makes it probable that pregnancy would result in a stillborn child; a further pregnancy would jeopardize a woman's mental health (e.g., she has two children now and can't cope with the stress, or she suffered a post-partum depression after a previous birth, or agonized over the removal of a child whom she was incapable of raising); or, as in the case of *Re K*, menstruation would produce a traumatic reaction because of a psychic fear of blood.

(ii) Sterilization for Contraception

9.21 Where the sterilization is for contraception the authority to perform it would also be obtained under the proposed legislation. Here the reason for the sterilization might be related to psychological, economic, social or other quality of life considerations where the element of clinical risk is lacking or of insufficient moment to justify a sterilization for medical treatment. Sterilization in this classification would include a situation where offspring are not wanted by the person to be sterilized; offspring would be an inordinate social and psychological burden to the person; the financial burden associated with raising children would be intolerable; or the care available for the person to be sterilized would become less personal (e.g., she may have to be moved out of the home if the family or other primary caregiver would be overburdened by the supervision of social conduct and monitoring of sexual activity or caring for offspring).

(iii) Recommendation

9.22 We recommend that sterilization for optional medical treatment and sterilization for contraception should be combined into a single category. We make this recommendation because we think that placing a boundary between sterilization for optional medical treatment and sterilization for contraception is not particularly helpful in answering the question whether sterilization would be of benefit to a minor or mentally incompetent adult in a particular case. Many of the considerations are overlapping.

9.23 We recommend that a sterilization falling within the combined category should be called an "elective sterilization". We would define an elective sterilization as one that is neither a sterilization for necessary medical treatment nor a hysterectomy for menstrual management.

(c) Hysterectomy for Menstrual Management

9.24 Where the purpose of the sterilization is menstrual management the authority to perform a hysterectomy would likewise be obtained under our proposed legislation. Although a hysterectomy for menstrual management is similar to an elective sterilization in that the reason for the operation is related to social or quality of life considerations more than to clinical prognosis, we have chosen to place it in a separate category because the sterilizing effect of the hysterectomy is secondary to the primary purpose of eliminating menses.

9.25 We would define a hysterectomy for menstrual management as one that has the elimination of menses as its primary purpose, is performed by the removal of the uterus and is not a sterilization for necessary treatment.

(3) Authority Provided by Legislation

9.26 It is our opinion that the proposed legislation should provide the exclusive source of authority for the sterilization of a minor or mentally incompetent adult. That is to say, no sterilization should be performed on such a person unless it is authorized in accordance with, or expressly excepted from, the legislation.

F. THE DECISION MAKER

9.27 We recommend the Court of Queen's Bench as the forum for decision. Our reasons for doing so are discussed in Chapter 8. To avoid any possibility of the legislation being interpreted to give the Master jurisdiction to authorize a sterilization, the legislation should specify that decisions should be made by a judge of the Court, rather than the Court itself.

9.28 The role of the judge would be to make the decision to authorize or refuse to authorize the sterilization. It would not be to authorize someone else (e.g., a parent or guardian) to decide. We think the decision places parents and guardians who are caregivers in a conflict of interest and should not be left to private judgment. Nor do we think it would make sense to invoke the protection afforded by the judicial machinery and then to give the judge a secondary role in the decision itself.

G. BASIS FOR STERILIZATION ORDER

9.29 Our first principle of reform makes the benefit of the sterilization to the person on whom it is performed the sole consideration.[267] But what approach should the judge take to the construction of the substantive sections of the legislation? On what substantive standard, what "test", should the decision be based?

9.30 We considered three possibilities: (i) the traditional common law welfare or "best interests" test; (ii) the "substituted judgment" test introduced into American jurisprudence in recent years; or (iii) the formulation of a new test based on notions of enhancing the quality of life likely to be experienced by the person to be sterilized, or of fostering normalcy.

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[267] *See supra*, para. 7.2.

(1) "Best Interests" Test

9.31 The "best interests" test is the test traditionally used for making decisions on behalf of another. It is the test used by the courts in the exercise of their *parens patriae* jurisdiction, and it is the basis for decision making by parents and guardians.

9.32 The test is not easily defined. It combines the objectivity of a reasonable person with the subjectivity of the circumstances of the particular individual for whom the decision is being made. Considerable discretion is left with the decision maker.

9.33 If the decision maker begins with a presumption against sterilization because it interferes with the privilege of giving birth and because the procedure is intrusive, the best interests test may be so difficult to satisfy that the option not to procreate would be effectively foreclosed. The Supreme Court of Canada rejected the "best interests" test as the basis for decision about sterilization for non-therapeutic, or "social", purposes in the unguided exercise of its *parens patriae* jurisdiction, although it did leave open the possibility of legislation to guide the courts.

9.34 Other courts, however, have held that drawing a line at the boundary between therapeutic and non-therapeutic sterilization is not helpful in determining whether a sterilization is in the best interests of a particular individual. The House of Lords, in the English case of *Re B*, held that the proper test is the best interests of the individual in all of the circumstances of the case. So did Anderson J. of the British Columbia Court of Appeal, in the Canadian case of *Re K* decided before *Eve*.

(2) "Substituted Judgment" Test

9.35 The "substituted judgment" test has been employed by some American courts in recent years as an alternative to the best interests test.[141] Under the substituted judgment test the decision is to be the one that would be made by the mentally incompetent person if she were mentally competent. The test requires the application of the subjective values of the individual insofar as they can be known. To apply it, an attempt must be made to ascertain the mentally incompetent person's actual preference for or against such matters as the sterilization, other means of contraception and parenthood.

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[141] *See infra*, Appendix H, paras. H29-H33.

9.36 The substituted judgment test was developed in terminal illness cases involving decisions about the use or removal of life support systems. The Supreme Judicial Court of Massachusetts used it as the basis for a sterilization decision in the case of *In Re Moe*.[369] This court found that the substituted judgment test best protects the mentally *incompetent* person by recognizing the dignity, worth and integrity of the person and affording him the same personal rights and choices that are afforded to persons in the mainstream of society.

9.37 The obvious difficulty with the application of the substituted judgment standard relates to persons who have been mentally incompetent from birth and who may therefore never have been able to express their values or desires. It may also be difficult to determine the values and desires of a person who was once competent but has been made incompetent by a supervening injury or disease. The Supreme Court of Canada rejected this test in the *Eve* case, decrying the sophistry involved in the fiction that a decision made in this way is the decision of the mentally incompetent person.[370]

(3) Other Tests

9.38 We explored the possibility of formulating a new test based on the enhancement of the overall "quality of life" of the person to be sterilized, or on building in the "normalization" principle. In applying a "quality of life" test, as we envisaged it, the judge would consider the opportunities, taken in the aggregate, available to a person for work, love, play and spiritual expression with or without the sterilization. He would also consider whether the person would have been likely to attain a higher level of satisfaction with life, again measured in the aggregate, with or without the sterilization. The "enhancement" of the quality of life experienced by a person would bring the person closer to the attainment of the highest level of satisfaction the person is capable of achieving. In applying the "normalcy" test, the judge would endeavour to allow the person to lead a life as similar as possible to that which the person would lead if the person were mentally competent.

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[369] *Supra* n. 221.

[370] *Supra* n. 2 at 34-35.

9.39 We also thought of combining the concepts of "quality of life" and "normalcy" to form a single test requiring the judge to make the decision that would best permit minors and adults who are not competent to experience lives that are equal in quality to the lives of persons who are in the mainstream of society.

9.40 Ultimately we concluded that our formulations were vague, uncertain and did not improve upon the "best interests" test.

(4) Recommendation

9.41 We favour the retention of the best interests test and recommend that it specified in the proposed legislation. This test has the advantage of being known to law. It is the one that is applied under the existing law to medical treatment decisions made by a parent or guardian for a person in his charge - a law that we do not propose should be disturbed. It is a flexible test capable of being applied to meet "all of the evolving dimensions" of the interests of the mentally incompetent person.[271] It permits the wishes, concerns, religious beliefs and other values of the person to be sterilized to be considered along with other factors relevant to the sterilization decision.

9.42 In the *Eve* case, the Supreme Court of Canada decided that a court applying the best interests test in the exercise of its *parens patriae* jurisdiction may do so only where the sterilization is therapeutic. Under our recommendation, the application of the best interests test is not limited to therapeutic sterilization. So that there may be no mistake about this, we recommend that the proposed legislation stipulate that the authority to perform a sterilization shall not be refused merely because the sterilization is not necessary for the protection of the physical or mental health of the person.

H. FACTORS JUDGE TO CONSIDER

(1) Elective Sterilization

9.43 It is our view that the legislation should include a mandatory list of factors for the judge to consider in applying the best interest test. We so recommend for a number of reasons.

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[271] Bernard M. Dickens, *supra* n. 17 at 271.

One is that, as the Supreme Court stated in the *Eve* judgment, judges - and the same could be said of lawyers - are not experts on sterilization. In the words of the Supreme Court:[272]

> Judges are generally ill-informed about many of the factors relevant to a wise decision in this difficult area. They generally know little of mental illness, of techniques of contraception or their efficacy.

Another is that the mixture of medical, genetic and social factors present for consideration complicates the job of the substitute decision maker. A third is that cases are known to have been decided under the Dependent Adults Act without adequate evidence (e.g. in one case, a sterilization was ordered of a person whose condition would have made him sterile already).

9.44 The list we have developed is a conglomerate, built from a variety of sources including the Canadian cases of *Re Eve* (in particular the judgment of McDonald J. on the appeal to the Prince Edward Island Supreme Court sitting *in banco*)[273] and *Re K*,[274], and American cases like *Re Grady*.[275] It includes the factors we will now discuss.

(a) Wishes of Person to be Sterilized

9.45 A person who is not competent to consent nevertheless may signal preferences or wishes that should be considered (e.g., the repeated plea of "no more babies", or the exhibition of violent aggression toward young children). A person may have expressed wishes before the onset of a disabling condition. Giving consideration to the wishes of the person would foster our third principle of reform.[276] That principle is that the law should respect the dignity, welfare and total development of the minor or mentally incompetent adult for whom sterilization is being considered.

9.46 The *Eve* judgment suggests that the wishes of the mentally incompetent person do not hold weight. A passage is quoted from the judgment of Mrs. Justice Heilbron in the English case of

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[272] *Supra* n. 2 at 32.

[273] *Supra* n. 130.

[274] *Supra* n. 16 and n. 141. *See* in particular the judgments of Wood J. at trial in the British Columbia Supreme Court and Anderson J. in the British Columbia Court of Appeal.

[275] *Supra* n. 222. *See also In re Guardianship of Hayes, supra* n. 221.

[276] *See supra*, paras. 7.22-7.23.

Re D (A Minor). It is to the effect that any answer given by a mentally incompetent person on the matter of sterilization, or any purported consent, would be valueless.[277] However, we think that insofar as they can be known, the wishes, concerns, religious beliefs or other values and special circumstances of the person to be sterilized should be considered.

(b) Mental Condition

9.47 Mental incompetence is a prerequisite to a substitute sterilization decision. But the relevance of mental condition does not end with this finding. Where there is a reasonable likelihood that the person to be sterilized will become competent to make the decision within a suitable time in the future, an elective sterilization ordinarily should not be authorized. In such a situation it would be proper for the judge to refuse to make an order. In sum, we recommend the nature and anticipated duration of the disabling condition should be a factor to be considered.

(c) Physical Capacity to Reproduce

9.48 It would be pointless and wrong to perform a sterilization on a person who is not capable of natural insemination or pregnancy (e.g., males with Down's Syndrome have not been known to reproduce, but a few affected females have had children).[278] Therefore, the physical capacity of the person to reproduce should be a factor for the judge to consider. However, because fertility is difficult to prove, we recommend that a presumption of fertility should be raised if the medical evidence indicates normal development of sexual organs and the evidence does not otherwise raise doubts about fertility.

(d) Engagement in Sexual Activity

9.49 The likelihood that the person will be sexually active is another factor that should be considered. In ordinary circumstances it would be excessive to sterilize a person where the likelihood is slight. Nor do we think that a sterilization should be performed to protect a person from possible sexual exploitation or abuse. The emphasis in such cases should be ***not*** on the curtailment of the choices available to the potential victim but on the curtailment of the undesirable behaviour by the perpetrator of the exploitation or abuse. Sterilization should not be used as a substitute for proper protection of mentally disabled persons from sexual abuse.

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[277] ***Re Eve, supra*** n. 2 at 20, quoting from ***Re D (A Minor), supra*** n. 200 at 332.

[278] James S. Thompson and Margaret W. Thompson, ***Genetics in Medicine*** (2nd ed. 1973) at 151.

(e) Risks to Physical Health

9.50 We recommend that the clinical risks to the physical health of the person of undergoing or foregoing the sterilization should be weighed as a fourth factor, just as they would be in the case of a mentally competent adult making her own decision.

(f) Risks to Mental Health

9.51 The clinical risks to the mental health of the person of undergoing or foregoing the sterilization should also be weighed. We have presented examples of traumatic or psychological risks associated with pregnancy and delivery.[279] The possible psychological effect of foregoing a sterilization should therefore be considered. Studies show that sterilization may engender a feeling of regret over the loss of the capacity to reproduce. It follows that the traumatic or psychological risks associated with undergoing a sterilization likewise should be considered.

(g) Alternatives to Sterilization

9.52 The availability and medical advisability of alternative means of medical treatment or contraception should be included as a factor for consideration. As a general rule, a sterilization should not be performed if a less restrictive means of medical treatment or contraception is available and feasible under the particular circumstances.[280]

(h) Likelihood of Marriage

9.53 Childbearing and rearing are normal incidents of marriage. Therefore we are of the view that the chances of the person for marriage in the future should be included as a factor.

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[279] *See e.g., supra* para. 4.93 quoting from *Re B.*, and para. 7.4.

[280] The meanings of the terms "least restrictive" and "least drastic" were explained earlier: *see* paras. 7.14-7.21.

(i) Risk of Disability in Child

9.54 Couples in the general population may seek genetic counselling to help them family planning. Where genetic considerations peculiar to a couple make it likely that their child will be born with a physical or mental disability, genetic counselling enables them to consider whether they would be able to cope satisfactorily. We think it likewise should be possible to consider evidence of genetic peculiarities in deciding whether a sterilization should be performed on a person who is not competent to consent.

(j) Ability to Care for a Child

9.55 Another factor that should be considered is the ability of the person to care for a child at the time of the application and any likely changes in that ability in the future.

(k) Other Available Care

9.56 Consideration should also be given to the care that may be available for prospective offspring (e.g., the help of a spouse, or a parent or other relative).

(l) Effect on Caregivers

9.57 We recommend that the likely effect of undergoing or foregoing the proposed sterilization on the ability of those who care for the person to provide required care should be a factor, but looked at only from the perspective of the person for whom sterilization is being considered. For example, would the person have to be moved to another residence because the burden of supervision without sterilization would be more than family caregivers are able to handle? Would the move or the sterilization best serve her interests?

(m) Opportunities for Satisfying Human Interaction

9.58 Satisfying human interaction may be experienced not only as a parent in the family setting, but also while working outside the home, enjoying a recreational activity, taking a bus, talking to a store clerk, engaging in normal sexual relations without fear of pregnancy, or participating in other ordinary daily life events. For some persons the opportunities for satisfying human interaction may be impaired rather than enhanced by the demands of childbearing and rearing.

We therefore recommend that the likely effect of the decision on the opportunities the person will have for satisfying human interaction should be a factor.

(n) Wishes of Family

9.59 The wishes, concerns, religious beliefs or other values of the family or other interested person may affect the interests of the person to be sterilized. To the extent that they do, they should be considered by the judge.

(o) Any Other Relevant Matter

9.60 The list of factors that we have specified, although extensive, is not exhaustive. We recommend that the judge should be able to give the matter the widest consideration possible. The last factor in the list should therefore direct the judge to consider any other matter that he considers relevant. The matter might be evidence that science or medicine is on the threshold of a breakthrough which could offer alternative and less drastic procedures for contraception. The matter might have to do with the advisability of performing a sterilization now rather than in the future - while sterilization should not be postponed until unwanted pregnancy occurs, neither should a sterilization be authorized before it has become clearly advisable. (Under our recommended legislation the denial of an application at one point in time would not preclude the making of a subsequent application in changed circumstances.)[181]

(2) Hysterectomy for Menstrual Management

9.61 Several of the factors listed for the judge to consider when the issue is elective sterilization are also relevant when the issue is hysterectomy for menstrual management. Such factors include: the mental condition of the woman to be sterilized; the risks to her physical health with or without the hysterectomy; the risks to her mental health with or without the hysterectomy; the alternative methods of menstrual management that are reasonably available; the effect of undergoing or foregoing the hysterectomy on the ability of those who care for the woman to provide the required care; the likely effect of undergoing or foregoing the hysterectomy on the woman's opportunities to experience satisfying human interactions; the wishes, concerns, religious beliefs and other values of the woman on whom it is proposed to perform the hysterectomy; the wishes, concerns, religious beliefs and other values of her family or other interested persons; and any other relevant matter, such as whether the decision should be made at the time of the application or postponed to a later date (e.g., the trial judge in *Re K* thought that the decision should wait until menstruation occurred and the anticipated reaction to menstrual blood was validated in fact).

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[181] *See infra*, paras. 9.109-9.110.

9.62 Other factors are not directly relevant to the issue of hysterectomy for menstrual management. They include: the physical capacity of the woman to reproduce; the likelihood that she will engage in sexual activity; the likelihood that she will marry; the risk of disability in offspring; her ability to care for a child who might be born; and other care available for such a child.

9.63 We recommend that the legislation should require the judge to consider the factors in the list for an elective sterilization that are relevant to the decision to perform a hysterectomy for menstrual management. The legislation should specify that a hysterectomy should not be ordered unless it is less drastic than the alternative methods reasonably available to control menstrual flow. The long term use of the injectable hormonal contraceptive Depo-provera, for example, suppresses menstrual bleeding, rendering it either irregular or absent for months. For this reason, it may be seen to have an advantage for menstrual management. The advantage, however, should be weighed against the possibility of an undetermined carcinogenic effect and the risks and side effects associated with estrogen that endure for the life of the injection.

(3) Availability of Evidence

9.64 Our recommendations place a duty on the judge to consider the factors listed before making an order authorizing the performance of an elective sterilization or a hysterectomy for menstrual management. There may be situations where evidence on a factor is either not available at all or not readily available. In such a situation the judge should be able to make an order in the absence of evidence. We recommend that he be authorized to do so where he is satisfied that evidence cannot reasonably be obtained.

I. METHOD OF STERILIZATION

9.65 For the most part, the choice of surgical operation or other medical procedure to be used for a sterilization is a matter to be governed by medical factors and evidence in the individual case. The choice will vary with the condition of the mentally incompetent person and the state of medical science at the time.

9.66 In our opinion, the least injurious or intrusive means of accomplishing the purpose should be used. Unless the medical evidence to the contrary is very persuasive it would be wrong, for example, to use hysterectomy for contraception. We therefore recommend that the legislation should include a section prohibiting the performance of an elective sterilization by hysterectomy unless the judge, by order, expressly so authorizes.

J. CONDITIONS OR RESTRICTIONS ON ORDER

9.67 In some cases, the circumstances may indicate that an order should be made subject to conditions (e.g., as to timing or method of sterilization to be used). We recommend that the judge should have the authority to make an order subject to any conditions or restrictions he considers necessary.

K. OTHER ORDERS JUDGE MAY MAKE

(1) Order Declaring Mental Competence

9.68 Because a finding of mental incompetence deprives the person of her right to self-determination by personal decision, the finding is critical to the outcome of the sterilization issue. A finding of mental incompetence removes a person's right to make an autonomous personal decision. Appropriately made, the finding serves to protect the interests of the mentally incompetent person; inappropriately made, it constitutes a serious infringement of individual rights.

9.69 When an application is before the court the judge must satisfy himself that the person in respect of whom the application is made is not competent to consent for herself. We recommend that, in addition, the legislation should authorize a judge to declare a person competent so that in a case of doubt the physician can rely on the consent given by the person, if an adult, to be sterilized for any purpose or, if a minor, to be sterilized for necessary medical treatment.

(2) Order Enjoining Sterilization

9.70 A judge exercising the general jurisdiction of a superior court may grant an injunction to enjoin illegal conduct or preserve an existing situation until the legal rights of the persons affected are determined. An injunction could be issued to enjoin the performance of a sterilization challenged as contrary to the best interests of a mentally incompetent person. If our recommendations are adopted, an injunction could be issued to enjoin the performance of a sterilization that has not been authorized by an order as required by the legislation.

9.71 We do not propose to disturb the law permitting the issue of an injunction. The general principles governing injunctions should continue to apply, as now, so that an injunction could be ordered in an appropriate case.

L. APPLICATION FOR ORDER

(1) Commencement of Proceedings

9.72 We recommend that proceedings for a sterilization order should be commenced by originating notice.[312] This is the method by which an application for guardianship is commenced under the Dependent Adults Act. No pleadings are required and the evidence may be taken by affidavit or orally at a hearing on the application. If the case is a complex one, or the evidence contentious, the judge may direct the trial of an issue and give directions as to the procedure to be followed.

(2) Applicant

9.73 In some of the reported cases decided under the *parens patriae* jurisdiction of the court, the proceedings have been commenced by a near relative of the minor or mentally incompetent adult (e.g., a parent as in *Re Eve*), perhaps at the insistence of a physician (e.g., as in *Re K*). In other cases, the proceedings have been initiated by a health care professional or other caregiver who is opposed to the sterilization and wishes to prevent it from being performed (e.g., as in *Re D*). Prior to the *Eve* decision, the Alberta Public Guardian had adopted the practice under the Dependent Adults Act of applying to the Surrogate Court for authority to have a sterilization for contraception or a hysterectomy for menstrual management performed on an adult under his guardianship. (As a consequence of the *Eve* decision, the Public Guardian no longer interprets the language of the Dependent Adults Act as being broad enough to permit consent to be given to the performance of a sterilization for a non-therapeutic purpose.)

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[312] Alberta Rules of Court, Alta. Reg. 390/68, Part 33 (Rules 404-410).

9.74 It is our opinion that because the sterilization, if ordered, would be in the best interests of the mentally incompetent person proceedings to determine those interests should be commenced with ease. No undue impediments should stand in the way of getting the matter before the Court. We therefore recommend that the legislation should permit an application to be brought by (i) the person to be sterilized, (ii) the Public Guardian where the person is an adult or the Children's Guardian where the person is a minor, or (iii) an interested person. We would define an "interested person" as an adult who, because of his relationship to the person in respect of whom an order is sought, is concerned for the welfare of the person.

9.75 In a case of doubt as to who is an interested person for the purpose of bringing an application, or for any other purpose under the legislation, a judge should be authorized to make an order resolving the issue.

(3) Representation of Person to be Sterilized

9.76 The provision of independent representation is, we think, a matter of fundamental importance to any reform of the law in this area. Recent American cases[283] provide for the appointment of an independent person, called a guardian *ad litem*, to protect the interests of the person with respect to whom an application is made before the court. The function they see for the guardian *ad litem* is to present proof, cross-examine and otherwise zealously represent the interests of the mentally disabled person. The Supreme Court of Canada judgment in the *Eve* case makes "independent representation" a requirement.

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[283] *In re Grady, supra* n. 222; *Wentzel* v. *Montgomery General Hospital, id.*; *In re Moe, supra* n. 221.

9.77 We recommend that a lawyer should be appointed to represent the interests of the person with respect to whom an application is brought, that the appointment should be made by a judge, and that it should be mandatory. The lawyer appointed should be competent to deal with the medical, legal, social and ethical issues involved.[194] The lawyer's role would be to make sure that the procedures laid down are followed and that full information regarding the issues of competence, sterilization, the alternatives and other matters set out in the list of factors for the judge to consider is presented so that the judge can be satisfied that his order is in the person's best interests.

9.78 To facilitate the appointment, the application should include a request for the direction of a judge with respect to the appointment of a lawyer to represent the interests of the person who is the subject of the application.

(4) Service of Notice

9.79 It is important to a full hearing of the issues that all persons with an interest in the outcome be notified of the proceeding and given an opportunity to participate. Such persons would ordinarily include the person whom it is sought to sterilize, the lawyer appointed to represent the person's interests, and parents or other legal guardians of the person, if any. We recommend that they should receive notice. (Because guardianship orders under the Dependent Adults Act are partial, not plenary, it could be argued that obligatory notice should be restricted to a guardian having the authority to consent to health care. We do not accept this argument. In our view any guardian appointed under the Dependent Adults Act is likely to be knowledgeable about the person and to have information that will be relevant to a full hearing of the sterilization issue in court. In any event, such a guardian should have the opportunity to decide whether to participate in the proceedings or not.)

9.80 We further recommend that where the person is an adult notice should be given to the Public Guardian; where she is a minor notice should be given to the Children's Guardian. Notice should also be given to the person in charge of the place in which the person resides if she is living in a "facility" instead of with a parent or guardian. We would define a facility as any establishment or class of establishment designated as such in the regulations under the legislation. Moreover, the judge should be able to require notice to be given to any other interested person (e.g., other concerned relatives or primary caregivers), or to dispense with unnecessary notice.

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[194] These were the desirable qualities identified by MacDonald J. of the Prince Edward Island Supreme Court, who dissented in part on the appeal of the *Eve* case in that province to the Court sitting *in banco*: *supra* n. 130 at 308.

9.81 Notice of proceedings commenced by originating notice is required, by Rule 406, to be given at least 10 days before the date on which the application is to be heard. Rule 406 would apply to the service of an application under our proposed legislation on a person in Alberta.

9.82 The Rules require the permission of the Court to effect service on a person out of Alberta.[285] The order authorizing the service must limit the time for response.[286] In contrast, the Dependent Adults Act expedites service out of Alberta by providing for service at least 30 days before the hearing on a person in another province, and at least 45 days before the hearing on a person in the United States.[287] We are attracted to this approach but do not see the need to make a distinction between service in another province and service in the United States. We recommend that the legislation should provide for service of notice on a person anywhere out of Alberta at least 30 days before the date of the hearing.

9.83 In some cases (e.g., where the purpose of an elective sterilization is optional medical treatment) a prompt decision may best serve the interests of the person to be sterilized. Although Rule 548 would permit a judge to abridge the time required for service within Alberta, the Rule would not permit a judge to shorten the time specified in a statute. Therefore, we recommend that the legislation should authorize a judge to make an order reducing the 30-day notice requirement for service out of Alberta.

(5) Right to Appear and be Heard

9.84 In our opinion, any person served or required to be served with an application and any other person whom the judge permits should be entitled to appear and be heard on an application. Our position is consistent with the provisions of s. 5 of the Dependent Adults Act.[288]

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[285] *Supra* n. 282, Rules 30 and 31.

[286] *Id.* Rule 31.

[287] *Supra* n. 102, s. 3(2.1).

[288] *Supra* n. 282, Rule 31.

(6) Evaluation of Person to be Sterilized

9.85 A comprehensive evaluation of the condition and circumstances of the person to be sterilized is central to the fair determination of the application.

9.86 Recent American cases hold that the evidence before the court should include independent evaluations of the person to be sterilized made by expert qualified professionals. The requirement has been supported in some Canadian judgments as well. On the Prince Edward Island appeal in *Re Eve*, for example, MacDonald J. stated:[289]

> The Court should receive advice based on comprehensive medical, psychological and social evaluation of the individual. It would be desirable that the individual be examined by a paediatrician or internists depending on age; a gynaecologist, urologist or general surgeon and a psychiatrist.

In *Re K*, Wood J. of the British Columbia Supreme Court added educational to medical, psychological and psychiatric evidence.[290]

9.87 It is our view that expert evidence should be introduced on an application under our proposed legislation. The evidence would assist the judge to determine the person's mental competence or incompetence and to weigh the advantages and disadvantages of the proposed sterilization. We make three recommendations in this regard.

9.88 Our first recommendation is that the applicant should be required to file the reports of a physician *and* a psychologist in support of an application for an order authorizing a sterilization.[291] The main purpose of the physician's report would be to provide a medical opinion about the person's physical and mental health and the risks to that health with or without sterilization. The main purpose of the psychologist's report would be to provide an expert opinion about the person's mental condition and the psychological consequences to the person of undergoing or foregoing the proposed sterilization. The reports should be served with the notice of the application.

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[289] *Supra* n. 130 at 308.

[290] *Supra* n. 141 at 231.

[291] This recommendation is modelled on the Dependent Adults Act, *supra* n. 102, s. 2(2) requiring the report of a physician *or* a psychologist to be filed with an application for guardianship.

9.89 We have intentionally chosen not to name a particular medical specialty. A physician is likely to be readily available whereas a gynecologist, psychiatrist or pediatrician may not be. The report of a specialist could always be obtained where appropriate.

9.90 Our second recommendation is that the lawyer appointed to represent the person's interests should be at liberty to apply to a judge for directions with respect to matters arising in the proceedings, including the engagement of experts to conduct independent evaluations and provide evidence. The lawyer should also be able to obtain directions for the payment of costs incurred in engaging experts and otherwise representing the person's interests.

9.91 Our third recommendation, which we discuss in the next section, is that where the judge has doubt as to whether an order should be made, he should have the power to conduct an investigation into the facts.

(7) Power of Judge to Inquire

9.92 Under the Dependent Adults Act, the court has a duty to ensure that the guardianship order is in the best interests of the person with respect to whom the order is made.[392] To aid in the fulfillment of the duty, the Act empowers the court to "appoint a person to prepare a report on the person named in the application with respect to any or all of his physical, mental, social, vocational, residential, educational, or other needs both present and future and generally his ability to care for himself and to make reasonable judgments with respect to matters relating to his person."[393]

9.93 Under our recommended legislation the decision made by the judge must also be in the best interests of the person to be sterilized. We therefore recommend that where he is not satisfied with the evidence provided the judge should be empowered to inquire further into the matter. We would frame the power more widely as a general power to investigate any matters the judge considers necessary. For this purpose, we would confer on the judge the powers of a commissioner appointed under the *Public Inquiries Act*. We recommend that the legislation should also require the judge to give the parties to the hearing a chance to be heard on the evidence produced and matters arising from an investigation.[294]

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[392] *Id.* s. 4(1).

[393] *Id.* s. 4(2). The section is particularly important to that Act because separate representation of the interests of the person who is the subject of the application is not a requirement of the legislation.

(8) Meeting with Person to be Sterilized

9.94 The person named in the application should be given every opportunity to express her own views about the judicial proceedings and the prospect of sterilization.[295] However, she may be unable to be present in court or the court may determine that her presence would not be useful in protecting her rights. In this situation we recommend that the judge, if he so chooses, should be able to meet with the mentally incompetent person. The purpose of the meeting would be for the judge to obtain his own impression of her mental competence and the likely effect on her of the proposed sterilization. The meeting would not have to be conducted formally. It could occur in a place convenient to the participants (e.g., the judge's chambers, counsel's office, or the place where the person to be sterilized resides).

9.95 We have mixed views about whether a legislative provision is needed. On balance, we recommend that one should be included in order to draw to the attention of the judge and parties the possibility of taking this extraordinary step.

(9) Cross-examination on Expert Reports

9.96 We are of the opinion that any party should have an opportunity to cross-examine the person making a report filed in the proceeding. The opportunity should encompass the reports of a physician and psychologist that must be filed with the application, the reports of independent experts engaged by the lawyer representing the interests of the person to be sterilized, the reports of persons conducting investigations pursuant to a direction of the judge made in furtherance of his power to inquire, and any other report.

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[294] The inspiration for these recommendations comes from the School Act, R.S.A. 1980 c. S-3 ss. 98(2) and (7).

[295] *In re Grady, supra* n. 222 at 482 (*per* Pashman J.).

(10) Other Matters

(a) Standard of Proof

9.97 The usual legal burden of proof in civil proceedings in Canada is proof on the balance of probabilities. The jurisprudence suggests that this standard may be applied so as to respond to the gravity of the consequences of the court's decision.[296]

9.98 American courts have developed a doctrine which requires clear and convincing evidence that a person lacks competence to consent to a sterilization. In those jurisdictions where the best interests standard is applied, the courts also require clear and convincing evidence that sterilization is in the best interests of the mentally incompetent person. That is to say, there is a presumption against sterilization.

9.99 The British Columbia Court of Appeal soundly rejected the introduction into Canada of the clear and convincing evidence rule in the case of *Re K*.[297] (The trial judge would have adopted it.) In its view the usual civil burden is sufficiently flexible to take into account the seriousness of the incompetence and sterilization decisions. The Supreme Court of Canada also rejected the rule in the case of *Re Eve*. The Court instead endorsed the usual civil rules, saying that "the burden, though a civil one, must be commensurate with the seriousness of the measure proposed".

9.100 Our objective is to substitute a wider jurisdiction for the jurisdiction of the court at common law to authorize a sterilization on behalf of a minor or mentally incompetent adult, not to make it more difficult to obtain the authority. For this reason we do not propose that the clear and convincing evidence rule should be statutorily introduced in Alberta.

9.101 What standard should be applied? There are two issues to consider. The first issue is the finding of mental incompetence. The finding is a prerequisite to the jurisdiction of the court to make a sterilization order. Where the person to be sterilized is an adult, the finding overturns the presumption of competence and removes from her the right to make the decision for herself. Because the finding disturbs existing rights, we think it should be subject to the ordinary civil burden as it is under the existing law. The onus of proof should remain on the applicant or other person alleging the mental incompetence.

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[296] See *Report of the Uniform Law Conference Federal/Provincial Task Force on Uniform Rules of Evidence* (1982) at 22-24.

[297] *Supra* n. 16 at 741-42 *per* Craig J.A. and at 747 *per* Anderson J.A. *See also M. v. Alberta* (1985) 63 A.R. 14 at 25-27; compare *Re Johannasen* (1984), 48 A.R. 15 at 18.

9.102 The second issue is the sterilization decision. We have said that the judge should make the decision that best serves the interests of the person in respect of whom the application is made. To enable him to do so where he is in doubt about what decision to make, we would give him the power to make whatever investigation of the matter he considers necessary. Here, we think that the standard of proof in the case should be to the satisfaction of the judge. Once the applicant has opened up the issue, the onus of proof should not rest with any party; instead, it should be up to the judge to satisfy himself of the person's best interests before making an order.

(b) Effective Date of Order

9.103 No sterilization should be performed until the time prescribed by the Rules of Court for appeal has elapsed or, where an appeal has been commenced, until it has been determined and the Court of Queen's Bench decision upheld. Under the present Rules the time allowed for filing and service of a notice of appeal is 20 days after a judgment, order or direction has been signed, entered or issued, and served.[298] The order should be endorsed with a statement to this effect.

(c) Costs

9.104 We have made the point that one disadvantage of a court application is the cost of the proceedings. In civil litigation the parties ordinarily are responsible to pay the costs, and the court has the discretion to order that they be paid by any one of the parties or apportioned between or among them.[299]

9.105 Where a proceeding is brought for the benefit of a dependent person, some Alberta statutes authorize the court to direct the Crown to pay the costs. The Dependent Adults Act affords one such example. Under it, the costs of a guardianship application may be awarded against the applicant, the person for whom an order of guardianship is sought or his estate where the court is satisfied that it would not be a hardship to order one or more of these persons to pay the costs.[300] They may also be awarded against the person making the application or a person opposing it where the application or opposition is frivolous or vexatious.[301] To alleviate hardship on the parties, the Act gives the court the additional discretion to order that the costs be paid by the Crown in Right of Alberta.[302]

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[298] Alberta Rules of Court, *supra* n. 282, Rules 506 and 510(1).

[299] *Id.* Rule 601.

9.106 The Child Welfare Act affords another example. Under that Act, where legal assistance is not available through legal aid or another source, the court may require the Attorney General to appoint, or cause to be appointed, a lawyer to represent a child who is the subject of an application for a supervision order or a temporary or permanent guardianship order.[303] Where it does so, the court is empowered to make an order directing that the costs of the lawyer be paid by the child, the guardian of the child or the Minister of Social Services, or be apportioned among all or any of them.[304] In exercising its discretion to direct the payment of costs, the court is to have regard to the means of the child and the guardian.[305]

9.107 In our proposed legislation, some members of our Board were inclined to recommend that where the resources of the person named in the application are inadequate for the purpose the judge should be able to direct that all or some of the costs (e.g., the independent expert evaluations) be paid by the Crown in Right of Alberta. Others argued that the government is currently practising economic restraint in an effort to reduce the budget deficit, and were concerned that a recommendation permitting a judge to order the payment of any costs by the Crown could conceivably impair the chances for the enactment of sterilization legislation.

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[300] Dependent Adults Act, *supra* n. 102, s. 48(a)(ii), (iii) and (iv).

[301] *Id.* s. 48(b).

[302] *Id.* s. 48(a)(i).

[303] Child Welfare Act, *supra* n. 83, s. 78.

[304] *Id.* s. 78(4).

[305] *Id.*

9.108 Our recommendation is for the adoption of a provision akin to section 48 of the Dependent Adults Act, but making the payment of costs by the Crown an avenue of last resort. An order for the payment of costs should be able to be made at any time after the commencement of an application (e.g., the lawyer appointed to represent the interests of the person named in the application may want to know to whom he should look for the payment of the costs associated with engaging experts to evaluate the person).

(d) Variation or Substitution of Order

9.109 A judge may refuse to make a sterilization order because the application is premature on the facts. Later a change of circumstances may occur making the time right for reapplication, or new evidence may surface after an order has been made and alter the wisdom of the previous decision. Because the purpose of the legislation is to facilitate the course of action that is in the best interests of the person concerned, we do not think that the fact that an order has been made previously should foreclose the bringing of a subsequent application.

9.110 We therefore recommend that, in appropriate circumstances, a judge should be able to vary or set aside a previous order and substitute a new order in its place. The circumstances would be that there has been a material change in the circumstances of the person to be sterilized, or that material evidence which was not previously before the court is now available, and that no substantial wrong or miscarriage of justice would result from varying or setting aside the original order and substituting another in its place.

(e) Appeal

9.111 It is the usual course in Alberta for an appeal to lie from the decision of a judge of the Court of Queen's Bench to the Court of Appeal.[306] This is the course that we recommend should be followed in respect of an order, direction or finding made by a judge under the proposed legislation.

(f) Regulation-Making Power

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[306] Alberta Rules of Court, *supra* n. 282, Rule 505(1).

9.112 Where the person to be sterilized is not living with a parent or guardian, our recommendations for notice require service to be made on the person in charge of the facility in which the person resides. We have recommended that a "facility" be defined to mean any establishment or class of establishment designated as a facility in the regulations.[107] Partner to that recommendation is our recommendation that the Lieutenant Governor in Council should be authorized to designate facilities. It may be appropriate to include in the designation institutions designated in the regulations under the Dependent Adults Act, facilities designated in the regulations under the Mental Health Act, and social care facilities licensed under the Social Care Facilities Licensing Act.

M. LOCATION OF LEGISLATION

9.113 We have not decided where the new legislation should be located. The proposed legislation shown in Part IV of this report has been drafted for enactment as a new statute. It could be reframed for incorporation into an existing statute. One possibility is the Dependent Adults Act. However, it is not entirely satisfactory to include minors in a statute for adults - placing the provisions for minors in a statute having to do with adults could obfuscate their existence from the parents and physicians making decisions for minors. If the legislature were to enact separate legislation to govern consent to health care for all persons, as we sometimes hear discussed, the provisions regarding sterilization might be located there.

9.114 If a new statute is enacted, it will need a name. Here again we are undecided about what it should be. We have thought of the Sterilization Act, or the Substitute Sterilization Decision Act, or the Sterilization Authorization Act.

9.115 We invite comment and suggestions.

N. AMENDMENT TO DEPENDENT ADULTS ACT

9.116 Clause (ii) of the definition of "health care" in paragraph (h) of section 1 of the Dependent Adults Act currently refers to:

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[107] *See supra*, para. 9.80.

(ii) any procedure undertaken for the purpose of preventing pregnancy.

We recommend that the Dependent Adults Act should be amended to clarify that the authority of a guardian on whom the authority "to consent to any health care that is in the best interests of the dependent adult" has been conferred under paragraph (h) of subsection (2) of section 10 does not extend to sterilization decisions that are governed by our recommended legislation. We would achieve this by adding to the end of clause (ii) the words "to which the [proposed sterilization legislation] does not apply".

PART III

LIST OF TENTATIVE RECOMMENDATIONS

LIST OF TENTATIVE RECOMMENDATIONS

A. RECOMMENDATION FOR LEGISLATION

RECOMMENDATION No. 1

We recommend that legislation be enacted to govern sterilization decisions.

[Para. 9.2]

B. PERSONS AFFECTED BY THE LEGISLATION

(1) Adults

RECOMMENDATION No. 2

We recommend that the proposed legislation apply to adults who are not competent to consent to a proposed sterilization.

[Para. 9.3]

RECOMMENDATION No. 3

We recommend that a sterilization of an adult who is competent to consent to it be specifically excepted from the operation of the proposed legislation.

[Para. 9.3;
Draft Act s. 2(1)(a)(ii)]

(2) Minors

RECOMMENDATION No. 4

We recommend that, subject to the exception set out in Recommendation No. 12, the proposed legislation should apply to minors.

[Paras. 9.4-9.7]

C. DEFINITION OF COMPETENCE

RECOMMENDATION No. 5

We recommend that the proposed legislation provide that an adult is competent to consent to an elective sterilization if he or she is able to understand and appreciate

(a) the nature and consequences of natural insemination, pregnancy and childrearing,

(b) the nature and consequences of the proposed sterilization including that it is or is likely to render the person permanently incapable of natural insemination or of becoming pregnant, and

(c) the consequences of giving or withholding consent.

[Para. 9.9;
Draft Act s. 1(2)(d)]

RECOMMENDATION No. 6

We recommend that the proposed legislation provide that a female adult is competent to consent to a hysterectomy for menstrual management if, in addition to being competent to consent to an elective sterilization, she is able to understand and appreciate

(a) the nature and consequences of menstruation, and

(b) the nature and consequences of the proposed hysterectomy including that the loss of the uterus will render her permanently incapable of becoming pregnant.

[Para. 9.9;
Draft Act s. 1(2)(e)]

D. DEFINITION OF STERILIZATION

RECOMMENDATION No. 7

We recommend that "sterilization" be defined in the proposed legislation as a surgical operation or other medical procedure or treatment that will or is likely to render a person permanently incapable of natural insemination or of becoming pregnant.

[Para. 9.10;
Draft Act s. 1(1)(d)]

E. SCOPE OF LEGISLATION

(1) Recap of Sterilization Purposes

(a) Medical Treatment

RECOMMENDATION No. 8

We recommend that the legislation permit a sterilization for medical treatment to be performed on a minor or adult who is not competent to consent.

[Paras. 7.3 and 9.11]

(b) Contraception

RECOMMENDATION No. 9

We recommend that the legislation permit a sterilization for contraception to be performed on a minor or adult who is not competent to consent, in an appropriate case.

[Paras. 7.4-7.5 and 9.11]

(c) Menstrual Management

RECOMMENDATION No. 10

We recommend that the legislation permit a hysterectomy for menstrual management to be performed on a female minor or adult who is not competent to consent, in an appropriate case.

[Paras. 7.6-7.8 and 9.11]

(2) Recommended Legislation

(a) Exception of Sterilization for Necessary Medical Treatment

RECOMMENDATION No. 11

We recommend that a "sterilization for necessary medical treatment" be defined in the proposed legislation as a sterilization that is medically necessary for the protection of the physical health of the person sterilized.

[Para. 9.18;
Draft Act s. 1(2)(a)]

RECOMMENDATION No. 12

We recommend that a sterilization for necessary medical treatment be excepted from the proposed legislation.

[Paras. 9.14-9.19;
Draft Act s. 2(1)(a)(i)]

(b) Elective Sterilization

RECOMMENDATION No. 13

We recommend that an "elective sterilization" be defined in the proposed legislation as a sterilization that is neither a sterilization for necessary medical treatment nor an hysterectomy for menstrual management.

[Para. 9.23;
Draft Act s. 1(2)(c)]

RECOMMENDATION No. 14

We recommend that the proposed legislation provide for the authorization of an "elective sterilization".

[Paras. 9.20-9.23;
Draft Act s. 3(1)(a)]

(c) Hysterectomy for Menstrual Management

RECOMMENDATION No. 15

We recommend that an "hysterectomy for menstrual management" be defined in the proposed legislation as a sterilization that

(a) is undertaken for the sole or primary purpose of eliminating menses,

(b) is performed by the removal of the uterus, and,

(c) is not a sterilization for necessary medical treatment.

[Para. 9.25;
Draft Act s. 1(2)(b)]

RECOMMENDATION No. 16

We recommend that the proposed legislation provide for the authorization of an "hysterectomy for menstrual management".

[Paras. 9.24-9.25;
Draft Act s. 3(1)(b)]

(3) Authority Provided by Legislation

RECOMMENDATION No. 17

We recommend that the proposed legislation prohibit the performance, on a minor or adult who is not competent to consent, of a sterilization that is not necessary for medical treatment unless the sterilization is authorized in accordance with the provisions of the proposed legislation.

[Para. 9.26;
Draft Act s. 2(2)]

F. THE DECISION MAKER

RECOMMENDATION No. 18

We recommend that a "judge" be defined in the proposed legislation as a judge of the Court of Queen's Bench.

[Para. 9.27;
Draft Act s. 1(1)(c)]

RECOMMENDATION No. 19

We recommend that the proposed legislation authorize a judge to make an order authorizing the performance of an elective sterilization or a hysterectomy for menstrual management.

[Paras. 9.29-9.28;
Draft Act s. 3(1)]

G. BASIS FOR STERILIZATION ORDER

RECOMMENDATION No. 20

We recommend that the interests of the minor or adult who is not competent to consent should be the sole consideration in the decision to perform an elective sterilization or a hysterectomy for menstrual management.

[Paras. 9.29-9.41]

RECOMMENDATION No. 21

We recommend that the proposed legislation specify the best interests test as the measure of the benefit of a sterilization to a minor or adult who is not competent to consent.

[Para. 9.41;
Draft Act s. 4(a)]

RECOMMENDATION No. 22

We recommend that the proposed legislation provide that a judge shall not refuse to make an order merely because the proposed sterilization is not necessary for the protection of physical or mental health.

[Para. 9.42;
Draft Act s. 4(b)]

(1) Elective Sterilization

RECOMMENDATION No. 23

We recommend that the proposed legislation require the judge, before making an order authorizing the performance of an elective sterilization, to consider

(a) the wishes, concerns, religious beliefs and other values of the family or other interested person insofar as they affect the interests of the person,

(b) the likelihood of the person ever becoming mentally competent to consent to the proposed sterilization,

(c) the physical capacity of the person to reproduce,

(d) the likelihood that the person will engage in sexual activity,

(e) the risks to the physical health of the person if the sterilization is or is not performed,

(f) the risks to the mental health of the person if the sterilization is or is not performed,

(g) the availability and medical advisability of alternative means of medical treatment or contraception,

(h) the likelihood that the person might in the future be able to marry,

(i) the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

(j) the ability of the person to care for a child at the time of the application and any likely changes in that ability,

(k) the likelihood that a child of the person could be cared for by some other person,

(l) the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care,

(m) the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

(n) the wishes, concerns, religious beliefs and other values of the family or other interested person insofar as they affect the interests of the person, and

(o) any other relevant matter that the judge considers relevant.

[Paras. 9.43-9.60;
Draft Act s. 5(1)]

RECOMMENDATION No. 24

We recommend that the proposed legislation raise a presumption of the physical capacity of the person to reproduce if the medical evidence indicates normal development of sexual organs and does not raise doubt to the contrary.

[Para. 9.46;
Draft Act s. 5(2)]

(2) Hysterectomy for Menstrual Management

RECOMMENDATION No. 25

We recommend that the proposed legislation require the judge, before making an order authorizing the performance of a hysterectomy for menstrual management, to consider

(a) the availability and medical advisability of alternative means of menstrual management, and

(b) such other matters in Recommendation No. 23 as the judge considers relevant.

[Paras. 9.61-9.63;
Draft Act s. 6(1)]

RECOMMENDATION No. 26

We recommend that the proposed legislation permit a hysterectomy to be ordered only where no less drastic alternative method of menstrual management is reasonably available.

[Para. 9.63;
Draft Act s. 6(2)]

(3) Availability of Evidence

RECOMMENDATION No. 27

Recommendations No. 23 and No. 25 notwithstanding, we recommend that the proposed legislation authorize the judge to make an order where he is satisfied that evidence in respect of a matter cannot reasonably be obtained.

[Para. 9.64;
Draft Act s. 5(3)]

H. METHOD OF STERILIZATION

RECOMMENDATION No. 28

We recommend that the proposed legislation prohibit the performance of an elective sterilization by hysterectomy except where expressly authorized by a judge.

[Paras. 9.65-9.66;
Draft Act s. 3(3)]

I. CONDITIONS OR RESTRICTIONS ON ORDER

RECOMMENDATION No. 29

We recommend that the proposed legislation permit the judge to make an order authorizing the performance of an elective sterilization or a hysterectomy for menstrual management subject to any conditions or restrictions the judge considers necessary.

[Para. 9.67;
Draft Act s. 3(2)]

J. OTHER ORDERS JUDGE MAY MAKE

(1) Order Declaring Mental Competence

RECOMMENDATION No. 30

We recommend that the proposed legislation authorize a judge, by order, to declare that a person is competent to consent to a proposed sterilization.

[Paras. 9.68-9.69;
Draft Act s. 7]

(2) Order Enjoining Sterilization

RECOMMENDATION No. 31

We recommend that the proposed legislation specify that nothing in the proposed legislation affects the jurisdiction of a judge to grant an injunction enjoining the performance of a sterilization.

[Paras. 9.70-9.71;
Draft Act s. 2(1)(b)]

K. APPLICATION FOR ORDER

(1) Commencement of Proceedings

RECOMMENDATION No. 32

We recommend that the proposed legislation provide that an application for an order authorizing the performance of an elective sterilization or a hysterectomy for menstrual management shall be made by originating notice.

[Para. 9.72;
Draft Act s. 9(1)(a)]

(2) Applicant

RECOMMENDATION No. 33

We recommend that the proposed legislation provide that an application may be brought by

(a) the person in respect of whom the order is sought,

(b) the Children's Guardian, where the person in respect of whom an order is sought is a minor,

(c) the Public Guardian, where the person in respect of whom an order is sought is an adult, or

(d) an interested person.

[Paras. 9.73-9.74;
Draft Act s. 8]

RECOMMENDATION No. 34

We recommend that an "interested person" be defined in the proposed legislation as an adult who, because of his relationship to the person in respect of whom an order is sought, is concerned for the welfare of the person.

[Para. 9.74;
Draft Act s. 1(1)(b)]

RECOMMENDATION No. 35

We recommend that the proposed legislation authorize a judge to make an order that a person is or is not an interested person for a purpose named in the proposed legislation.

[Para. 9.75;
Draft Act s. 11]

(3) Representation of Person to be Sterilized

RECOMMENDATION No. 36

We recommend that the proposed legislation require the application to include a request for the direction of a judge with respect to the appointment of a lawyer to represent the interests of the person in respect of whom the application is made.

[Paras. 9.76-9.78;
Draft Act s. 9(1)(b)]

RECOMMENDATION No. 37

We recommend that the proposed legislation require a judge, before an application is heard, to appoint a lawyer to represent the interests of the person in respect of whom an application is made.

[Para. 9.77;
Draft Act s. 13]

(4) Service of Notice

RECOMMENDATION No. 38

We recommend that the proposed legislation provide that the applicant shall serve notice on

(a) the person in respect of whom the application is made,

(b) the parents or guardians of the person in respect of whom the application is made, if any,

(c) the person in charge of the facility, if the person in respect of whom the application is made is a resident of the facility,

(d) the Children's Guardian, if the person in respect of whom the application is made is a minor,

(e) the Public Guardian, if the person in respect of whom the application is made is an adult,

(f) the lawyer appointed under Recommendation No. 37, and

(g) any other interested person whom a judge may direct.

[Paras. 9.79-9.81;
Draft Act s. 10(1)]

RECOMMENDATION No. 39

We recommend that the proposed legislation provide that no order for service *ex juris* is required but service outside Alberta must be effected at least 30 days before the date set for the hearing of the application, unless otherwise ordered by a judge.

[Paras. 9.82-9.83;
Draft Act s. 10(2)]

RECOMMENDATION No. 40

We recommend that the proposed legislation provide that a judge may dispense with service on the person in respect of whom the application is made if satisfied that it is in the best interests of the person to do so, and the lawyer appointed under Recommendation No. 37 consents.

[Para. 9.80;
Draft Act s. 10(3)(a)]

RECOMMENDATION No. 41

We recommend that the proposed legislation provide that a judge may dispense with service on any or all of the other persons referred to in Recommendation No. 40 except

(a) the lawyer appointed under Recommendation No. 37,

and

(b) the Children's Guardian, if the person in respect of whom the order is made is a minor, or

(c) the Public Guardian, if the person in respect of whom the order is made is an adult.

[Para. 9.80;
Draft Act s. 10(3)(b)]

RECOMMENDATION No. 42

We recommend that a "facility" be defined in the proposed legislation as any establishment or class of establishment designated as a facility in the regulations under the proposed legislation.

[Para. 9.80;
Draft Act s. 1(1)(a)]

(5) Right to Appear and be Heard

RECOMMENDATION No. 43

We recommend that the proposed legislation permit a person served or required to be served under Recommendation No. 38 or any other person whom the judge permits to appear and be heard on an application.

[Para. 9.84;
Draft Act s. 12]

(6) Evaluation of Person to be Sterilized

RECOMMENDATION No. 44

We recommend that the proposed legislation require the applicant for an order to file the reports of a physician and a psychologist in support of the application.

[Paras. 9.85-9.89;
Draft Act s. 9(2)]

RECOMMENDATION No. 45

We recommend that the proposed legislation permit the lawyer appointed under Recommendation No. 37 to apply to a judge for directions on any matter arising in the proceedings, including

(a) the engagement of experts to provide evidence,

(b) the payment of costs incurred in representing the interests of the person in respect of whom the application is made.

[Para. 9.90;
Draft Act s. 14]

(7) Power of Judge to Inquire

RECOMMENDATION No. 46

We recommend that the proposed legislation authorize the judge hearing the application to make whatever investigation he considers necessary with respect to any matter relating to the application.

[Paras. 9.91-9.93;
Draft Act s. 16(1)]

RECOMMENDATION No. 47

We recommend that, for the purpose of making an investigation under Recommendation No. 46, the proposed legislation confer on the judge the powers of a Commissioner under the *Public Inquiries Act*.

[Para. 9.93;
Draft Act s. 16(2)]

RECOMMENDATION No. 48

We recommend that the proposed legislation require the judge to give the parties an opportunity to be heard with respect to the evidence produced in matters arising from an investigation made under Recommendation No. 46.

[Para. 9.93;
Draft Act s. 16(3)]

(8) Meeting with Person to be Sterilized

RECOMMENDATION No. 49

We recommend that the proposed legislation require the judge to meet personally with the person named in the application where he is of the opinion that he should do so.

[Paras. 9.94-9.95;
Draft Act s. 15]

(9) Cross-examination on Expert Reports

RECOMMENDATION No. 50

We recommend that the proposed legislation permit any party to cross-examine the person making a report filed in a proceeding under the proposed legislation.

[Para. 9.96;
Draft Act s. 17]

(10) Other Matters

(a) Standard of Proof

RECOMMENDATION No. 51

We recommend that the proposed legislation require a judge, before making an order, to be satisfied that the proposed sterilization would be in the best interests of the person to be sterilized.

[Paras. 9.97-9.102;
Draft Act s. 4(a)]

(b) Effective Date of Order

RECOMMENDATION No. 52

We recommend that the proposed legislation provide that an order shall not take effect until

(a) the dismissal or discontinuance of the appeal, where an appeal has been filed, or

(b) the expiration of the time allowed for appeal, where no appeal has been filed.

[Para. 9.103;
Draft Act s. 18]

RECOMMENDATION No. 53

We recommend that the proposed legislation require the order to be endorsed in accordance with Recommendation No. 52.

[Para. 9.103;
Draft Act s. 18]

(c) Costs

RECOMMENDATION No. 54

We recommend that the proposed legislation permit a judge, at any time after the commencement of an application, to make an order that the costs of any application made or report or investigation ordered

(a) be paid by any or all of

(i) the person making the application;

(ii) the person in respect of whom the application is made;

(iii) the estate of the person in respect of whom the application is made where a trustee of the estate has been appointed;

(iv) the Crown in right of Alberta, where the judge is satisfied that it would be a hardship for any or all of the parties named in clauses (i), (ii) or (iii) to do so;

or

(b) be paid by the person making the application or a person opposing the application, where the judge is satisfied that the application or the opposition to the application, as the case may be, is frivolous or vexatious.

[Paras. 9.104-9.108;
Draft Act s. 19]

(d) Variation or Substitution of Order

RECOMMENDATION No. 55

We recommend that the proposed legislation provide that where a judge is satisfied that, since the making of an order

(a) there has been a material change in the circumstances of the person in respect of whom the application was brought, or

(b) material evidences available which was not previously before the court,

and

(c) no substantial wrong or miscarriage of justice would result from his doing so,

he may

(d) vary or set aside the order, and

(e) make an order in substitution for an order that has been set aside.

[Paras. 9.109-9.110;
Draft Act s. 20]

(e) Appeal

RECOMMENDATION No. 56

We recommend that the proposed legislation permit any party to or person heard on an application to appeal the order of a judge to the Court of Appeal of Alberta.

[Para. 9.111;
Draft Act s. 21(1)]

RECOMMENDATION No. 57

We recommend that the legislation require the notice of appeal to be served on

(a) the lawyer appointed under Recommendation No. 37,

(b) the Children's Guardian, if the person in respect of whom the order is made is a minor,

(c) the Public Guardian, if the person in respect of whom the order is made is an adult,

(d) any interested person who appeared and made representations on the application before a judge in the Court, and

(e) any other interested person whom a judge of the Court of Appeal of Alberta may direct.

[Para. 9.111;
Draft Act s. 21(2)]

(f) Regulation-Making Power

RECOMMENDATION No. 58

We recommend that the legislation authorize the Lieutenant Governor in Council to make regulations designating any establishment or class of establishment as a facility.

[Para. 9.112;
Draft Act s. 22]

M. LOCATION OF LEGISLATION

No recommendation.

[Paras. 9.113-9.114]

N. AMENDMENT TO DEPENDENT ADULTS ACT

RECOMMENDATION No. 59

We recommend that the definition of "health care" in the Dependent Adults Act be amended to except a sterilization to which the proposed legislation applies from the authority of a guardian appointed to consent to the health care of a dependent adult.

[Para. 9.116;
Draft Dependent Adults
Amendment Act
see infra, p. 149]

PART IV

PROPOSED LEGISLATION

[Substitute Sterilization Decision Act]

[Interpretation]

1(1) In this Act,

(a) "facility" means any establishment or class of establishment designated as a facility in the regulations under this Act;

[Recommendation No. 42]

(b) "interested person" means an adult who, because of his relationship to the person in respect of whom an order is sought, is concerned for the welfare of the person;

[Recommendation No. 34]

(c) "judge" means a judge of the Court of Queen's Bench;

[Recommendation No. 18]

(d) "sterilization" means a surgical operation or other medical procedure or treatment that will or is likely to render a person permanently incapable of natural insemination or of becoming pregnant.

[Recommendation No. 7]

(2) For the purposes of this Act,

(a) a "sterilization for necessary medical treatment" is a sterilization that is medically necessary for the protection of the physical health of the person sterilized;

[Recommendation No. 11]

(b) an "hysterectomy for menstrual management" is a sterilization that

(i) is undertaken for the sole or primary purpose of eliminating menses,

(ii) is performed by the removal of the uterus, and

(iii) is not a sterilization for necessary medical treatment;

[Recommendation No. 15]

(c) an "elective sterilization" is a sterilization that is neither a sterilization for necessary medical treatment nor an hysterectomy for menstrual management;

[Recommendation No. 13]

(d) an adult is competent to consent to an elective sterilization if he or she is able to understand and appreciate

(i) the nature and consequences of natural insemination, pregnancy and childrearing,

(ii) the nature and consequences of the proposed sterilization including that it will or is likely to render the person permanently incapable of natural insemination or of becoming pregnant, and

(iii) the consequences of giving or withholding consent, and

[Recommendation No. 5]

(e) a female adult is competent to consent to a hysterectomy for menstrual management if, in addition to the matters described in clauses (i), (ii) and (iii) of paragraphs (d), she is able to understand and appreciate

(i) the nature and consequences of menstruation, and

(ii) the nature and consequences of the proposed hysterectomy including that the loss of the uterus will render the person permanently incapable of becoming pregnant.

[Recommendation No. 6]

[Scope]

2(1) Nothing in this Act affects

(a) the law regarding the performance of

(i) a sterilization for necessary medical treatment, or

(ii) a sterilization of an adult who is competent to consent to sterilization;or

[Recommendations No. 3 & No. 12]

(b) the jurisdiction of a judge to grant an injunction enjoining the performance of a sterilization.

[Recommendation No. 31]

(2) No sterilization other than a sterilization for necessary medical treatment shall be performed on

(a) a minor, or

(b) an adult who is not competent to consent to the proposed sterilization

unless it is authorized by an order made under this Act.

[Recommendation No. 17]

Part 1 - Sterilization Orders

[Sterilization Orders Judge May Make]

3(1) A judge may make an order authorizing the performance of

(a) an elective sterilization, or

(b) a hysterectomy for menstrual management

on a person who is

(c) a minor, or

(d) an adult who is not competent to consent to the proposed sterilization.

[Recommendations No. 14,
No. 16 & No. 19]

(2) The judge may make the order subject to any conditions or restrictions he considers necessary.

[Recommendation No. 29]

(3) No elective sterilization shall be performed by hysterectomy unless a judge, by order, expressly so authorizes.

[Recommendation No. 28]

[Judge Must be Satisfied]

4. A judge shall not

(a) make an order under subjection (1) of section 3 unless he is satisfied that the proposed sterilization would be in the best interests of the person to be sterilized;

[Recommendations No. 21 &
No. 51]

(b) refuse to make an order under subsection (1) of section 3 merely because the sterilization is not necessary for the protection of physical or mental health.

[Recommendation No. 22]

[Decision to Make Order for Elective Sterilization]

5(1) Before making an order authorizing the performance of an elective sterilization, the judge shall consider

(a) the wishes, concerns, religious beliefs and other values of the person,

(b) the likelihood of the person ever becoming mentally competent to consent to the proposed sterilization,

(c) the physical capacity of the person to reproduce,

(d) the likelihood that the person will engage in sexual activity,

(e) the risks to the physical health of the person if the sterilization is or is not performed,

(f) the risks to the mental health of the person if the sterilization is or is not performed,

(g) the availability and medical advisability of alternative means of medical treatment or contraception,

(h) the likelihood that the person might in the future be able to marry,

(i) the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

(j) the ability of the person to care for a child at the time of the application and any likely changes in that ability,

(k) the likelihood that a child of the person could be cared for by some other person,

(l) the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care,

(m) the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

(n) the wishes, concerns, religious beliefs and other values of the family or other interested person insofar as they affect the interests of the person, and

(o) any other matter that the judge considers relevant.

[Recommendation No. 23]

(2) For the purpose of paragraph (b) of subsection (1) the physical capacity of the person to reproduce shall be presumed if the medical evidence indicates normal development of sexual organs and does not raise doubt to the contrary.

[Recommendation No. 24]

(3) The judge may make an order without considering a matter named in subsection (1) of this section or subsection (1) of section 6 where the judge is satisfied that evidence in respect of it cannot reasonably be obtained.

[Recommendation No. 27]

[Decision to Make Order for Hysterectomy for Menstrual Management]

6(1) Before making an order authorizing the performance of an hysterectomy for menstrual management the judge shall consider

(a) the availability and medical advisability of alternative means of menstrual management,and

(b) such other matters in section 5 as the judge considers relevant.

[Recommendation No. 25]

(2) An hysterectomy for menstrual management shall be ordered only where no less drastic alternative method of menstrual management is reasonably available.

[Recommendation No. 26]

[Declaration of Mental Competence]

7. Where a judge finds that an adult person is mentally competent to consent to a proposed sterilization the judge may, by order, so declare.

[Recommendation No. 30]

Part 2 - Application for Order

[Applicant]

8. An application for an order under this Act may be made by

(a) the person in respect of whom the order is sought,

(b) the Children's Guardian, where the person in respect of whom an order is sought is a minor,

(c) the Public Guardian, where the person in respect of whom an order is sought is an adult, or

(d) an interested person.

[Recommendation No. 33]

[Commencement by Originating Notice]

9(1) The application shall

(a) be made by originating notice, and

(b) include a request for the direction of a judge with respect to the appointment of a lawyer under section 13.

[Recommendations No. 32 &
No. 36]

(2) The applicant shall file in support of the application the reports of

(a) a physician, and

(b) a psychologist.

[Recommendation No. 44]

[Service of Notice]

10(1) The applicant shall service notice of the application on

(a) the person in respect of whom the application is made,

(b) the parents or guardians of the person in respect of whom the application is made, if any,

(c) the person in charge of the facility, if the person in respect of whom the application is made is a resident of a facility,

(d) the Children's Guardian, if the person in respect of whom the application is made is a minor,

(e) the Public Guardian, if the person in respect of whom the application is made is an adult,

(f) the lawyer appointed under section 13, and

(g) any other interested person whom the Court may direct.

[Recommendation No. 38]

(2) No order for service *ex juris* is required for service under subsection (1), but service outside Alberta must be effected at least 30 days before the date set for the hearing of the application, unless otherwise ordered by a judge.

[Recommendation No. 39]

(3) A judge may

(a) dispense with service on the person in respect of whom the application is made if satisfied that it is in the best interests of that person to do so, and the lawyer appointed under section 13 consents; or

(b) dispense with service on any or all of the other persons referred to in subsection (1) except

(i) the lawyer appointed under section 13,

and

(ii) the Children's Guardian, if the person in respect of whom the order was made is a minor, or

(iii) the Public Guardian, if the person in respect of whom the order is made is an adult.

[Recommendations No. 40 & No. 41]

[Interested Person]

11. A judge may make an order that a person is or is not an interested person for a purpose named in this Act.

[Recommendation No. 35]

[Persons Who May be Heard]

12. A person served or required to be served under subsection (1) of section 10 or any other person whom the judge permits may appear and be heard on an application under this Act.

[Recommendation No. 43]

[Representation]

13. Before an application is heard, a judge shall appoint a lawyer to represent the interests of the person in respect of whom the application is made.

[Recommendation No. 37]

[Motion for Directions]

14. The lawyer appointed under section 13 may at any time apply to a judge for directions with respect to any matter arising in the proceedings, including

(a) the engagement of experts to provide evidence, and

(b) the payment of costs incurred in representing the interests of the person in respect of whom the application is made.

[Recommendation No. 45]

[Meeting with Person in respect of Whom Application Made]

15. Where for any purpose connected with the application the judge is of the opinion that he should meet personally with the person in respect of whom the application is made, he shall do so.

[Recommendation No. 49]

[Investigation by Judge]

16(1) The judge may make whatever investigation he considers necessary with respect to any matter relating to the application.

[Recommendation No. 46]

(2) For the purpose of making an investigation pursuant to this section, the judge has the powers of a commissioner under the *Public Inquiries Act*.

[Recommendation No. 47]

(3) The judge shall give the parties an opportunity to be heard with respect to the evidence produced and matters arising from an investigation.

[Recommendation No. 48]

[Expert Reports]

17. Any party may cross-examine the person making a report filed in a proceeding under this Act.

[Recommendation No. 50]

Part 3 - General

[Effective Date of Order]

18. Notwithstanding anything in the Rules of Court to the contrary, an order under this Act shall not take effect until

(a) the dismissal or discontinuance of the appeal, where an appeal has been filed, or

(b) the expiration of the time allowed for appeal, where no appeal has been filed,

and the order shall be so endorsed.

[Recommendations No. 52 & No. 53]

[Costs]

19. A judge may at any time after the commencement of an application under Part 3 make an order that the costs of any application made or report or investigation ordered

(a) be paid by any or all of

(i) the person making the application;

(ii) the person in respect of whom the application is made;

(iii) the estate of the person in respect of whom the application is made where a trustee of the estate has been appointed;

(iv) the Crown in right of Alberta, where the judge is satisfied that it would be a hardship for any or all of the parties named in clauses (i), (ii) or (iii) to do so;

or

(b) be paid by the person making the application or a person opposing the application, where the judge is satisfied that the application or the opposition to the application, as the case may be, is frivolous or vexatious.

[Recommendation No. 54]

[Order to Vary or Set Aside]

20. Where a judge is satisfied that, since the making of an order under this Act,

(a) there has been a material change in the circumstances of the person in respect of whom the application was brought, or

(b) material evidence is available which was not previously before the court,

and

(c) no substantial wrong or miscarriage of justice would result from his doing so,

he may

(d) vary or set aside the order, and

(e) make an order in substitution for an order that has been set aside.

[Recommendation No. 55]

[Appeals]

21(1) Any party to or person heard on an application under this Act may appeal the order of a judge to the Court of Appeal of Alberta.

[Recommendation No. 56]

(2) The notice of appeal shall be served on

(a) the lawyer appointed under section 13,

(b) the Children's Guardian, if the person in respect of whom the order was made is a minor,

(c) the Public Guardian, if the person in respect of whom the order is made is an adult,

(d) any interested person who appeared and made representations on the application in the Court, and

(e) any other interested person whom a judge of the Court of Appeal of Alberta may direct.

[Recommendation No. 57]

[Regulation-Making Power]

22. The Lieutenant-Governor in Council may, for the purposes of this Act, make regulations designating any establishment or class of establishment as a facility.

[Recommendation No. 58]

Dependent Adults Amendment Act

1. This Act amends the Dependent Adults Act.

2. The definition of "health care" in paragraph (h) of section 1 is amended by adding, at the end of clause (ii), the words "to which the [proposed sterilization legislation] does not apply".

[Recommendation No. 59]

APPENDIX A

METHODS OF STERILIZATION[1]

A. MALES

A1. The two methods of male sterilization are *castration* and *vasectomy*. Castration is the irreversible surgical removal of the testicles (the male reproductive glands). Use of the procedure is rare but may be required for treatment of a malignancy.

A2. Vasectomy is the usual contraceptive procedure for males. It consists of the excision of a segment of the duct (*vas deferens*) that carries spermatic fluid from the testicles to the penis canal. The surgical procedure is simple. It can usually be done in 20 minutes under local anesthetic in a hospital on an outpatient basis or in a physician's office. The procedure may be reversed by the reconnection of the ends of the duct excised by vasectomy. The success rate, measured by the reappearance of sperm in the ejaculate, is 40 to 90% of cases. However, functional success (subsequent impregnation) is less frequent (18 to 60%).[2]

B. FEMALES

A3. The three methods of female sterilization are *oophorectomy*, *tubal occlusion* and *hysterectomy*. Oophorectomy is the surgical removal (excision) of the ovaries (the female reproductive gland). It is the equivalent of castration in males. Use of the procedure is rare but, like castration, it may be required for the treatment of a malignancy.

A4. Tubal occlusion (or "tubal sterilization") is the usual contraceptive procedure for females. It may also be used for medical treatment where a future pregnancy would greatly risk the health of the mother. It consists of closing the fallopian tube (oviduct) so that sperm are prevented from reaching and fertilizing the ovum (female egg) released once a month by the ovaries.

A5. Most methods of tubal occlusion consist of minor surgery. The conventional approach to the tubes is by an abdominal incision. As technology has improved the traditional large abdominal incision into the loin (laparotomy) has been replaced by a small abdominal incision (minilaparotomy) or puncture (laparoscopy). Another approach is by a cutting operation into the vagina (colpotomy or culdoscopy).

A6. No satisfactorily reversible technique of tubal occlusion has yet been developed. Although all the acceptable techniques are considered irreversible, some are less irreversible than others. Techniques which preserve the length of the tube and the blood supply afford a better chance of success in re-establishing tubal function. The techniques that are readily reversible are, however, associated with slightly higher failure (i.e. spontaneous reversal) or pregnancy rates. There may be an appreciable risk of tubal (ectopic) pregnancy following restitution of tubal continuity.[3]

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[1] As part of our research, we conducted a more extensive study of the procedures, the medical considerations attending the procedures and the psychological effects. Most of the studies of psychological effects have been made of persons in the general population but we also looked into the literature on the psychological impact of sterilization on persons with below average intelligence (mentally retarded persons). Our unpublished research papers can be made available on request.

[2] R.C. Benson, *Current Obstetric and Gynecologic Diagnosis and Treatment* (3rd ed. 1980).

[3] J.A. Pritchard and P.C. Macdonald, *William's Obstetrics* (16th ed. 1980).

A7. Hysterectomy is the removal of the uterus, usually through an incision in the abdominal wall (although it may be carried out vaginally). It puts an end to menstruation. It is a major surgical procedure and carries a much higher risk of death (at least 10 to 20 times greater) or complication than tubal occlusion. The death rates for hysterectomy performed during pregnancy or Caesarian section or after delivery are far in excess of those associated with either normal childbirth or Caesarian section. Hysterectomy between pregnancies still has 3 to 5 times the risk of complication and death of laparotomy.[4]

A8. Because the risks are high, hysterectomy is difficult to justify except for a medical reason (*e.g.* uterine or other pelvic disease; or dysfunctional uterine bleeding not responsive to hormone therapy; or rupture of cervix during abortion of woman over 49 years of age).[5]

A9. At least one surgeon,[6] however, sees the following advantages of hysterectomy including oophorectomy for healthy young women:

(i) no further worries about contraception or abortion;

(ii) complete protection against death from three fairly common types of cancer - those of the cervix, uterus and ovary;[7] and

(iii) reduction of the risk of breast cancer.

A10. Hysterectomy has been advocated on the ground that 6 to 25% of tubally sterilized women subsequently require hysterectomy,[8] but others have observed that the figures leave 75 to 94% of women successfully sterilized by a much safer tubal method without the need for subsequent hysterectomy.[9]

A11. It is noteworthy that a higher incidence of psychological problems has been associated with hysterectomy than with tubal occlusion.[10] If a woman perceives her uterus as a symbol of her femininity, sexuality and vitality, she may feel its loss more acutely than the loss of the reproductive function alone.[11] For sterilization in general, there is evidence that the risk of regret is higher in childless women and greater for persons sterilized under compulsion rather than with personal consent.[12] In the latter case, the woman may interpret the sterilization as a sign of reduced or degraded status in one unworthy to experience the joys of parenthood.[13] We speculate that such a sense of loss would be unlikely to engulf a person who is mentally incompetent to comprehend reproduction in the first place.

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[4] J.D. Keeping et al., "Sterilization: A Comparative Review". (1979) 19 *Aust. N.Z. J. Obstet. and Gynaecol.* 193-202.

[5] M.C.E. Cheng, "Abdominal Sterilization" in *Abortion and Sterilization* (J.E. Hodgson ed. 1981).

[6] George Crile, Jr., *Surgery* (1978).

[7] The author of an older medical text claims that the only known potential for the uterus other than to house products of conception is to harbour disease: *Williams Obstetrics*. Another author writes that "The uterus has but one function: reproduction. After the last pregnancy it becomes a useless, bleeding, sympton-producing, potentially carcinoma bearing organ and therefore should be removed": R.C. Wright, "Hysterectomy: Past, present, and future" (1969) 33 *Obstet. and Gynaecol.* 560.

[8] W.D. Edgerton, "Late Complications of Laparascopic Sterilization" (1977) *J. Reprod. Med.* 18; R.B. Whitelaw, "10-year Survey of 485 Sterilizations" (1979) 1 *Brit. Med. J.* 32.

[9] Keeping et al., *supra* n. 4.

[10] P. Barglow et al., "Hysterectomy and Tubal Ligation: A Psychiatric Comparison" (1965) 25 *Obstet. Gynecol.* 520-7.

[11] M.G. Drellich and I. Bieber, "The Psychologic Importance of the Uterus and its Functions" (1958) 126 *J. Nerv. Ment. Dis.* 322-36; J.R. Mathis, "The Emotional Impact of Surgical Sterilization of the Female" (1969) 62 *Okla. Med. H.S.S. J.* 141-5.

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[12] M. Ekblad, "Social-psychiatric Prognosis after Sterilization of Women Without Children" (1963) 39 *Acta. Psychiat. Scand.* 481.

[13] G. Sabagh and R.B. Edgerton, "Sterilized Mental Defectives Look at Eugenic Sterilization" (1962) 9 *Eugenics Quarterly* 213-22; Robert B. Edgerton, *The Cloak of Competence* (1967) 49.

APPENDIX B

MENTAL RETARDATION

Mental Retardation: Sometimes a Source of Mental Incompetence

A. CLASSIFICATION AS MENTALLY RETARDED

B1. Earlier in the century, mental retardation was defined in terms of low performance on standardized intelligence tests ("IQ"). Low IQ is still a necessary component of classification as mentally retarded. There is, however, considerable variation in the everyday functioning of retarded persons of the same mental age or IQ. That is to say, some persons are more successful than others in coping with the everyday demands presented by their environment. For this reason, assessment and classification systems in current use are two- rather than uni-dimensional. These systems measure not only IQ (the tests for IQ have shortcomings) but also "adaptive behaviour" or "functional level".

B2. Whereas the determination of IQ is statistically based, the assessment of functional level is largely subjective. Standardized descriptions (or "scales") of behaviour have been developed to aid in formal appraisal, classification as mentally retarded or not and placement at one or another level of mental retardation. Because in normal development abilities grow with age the descriptions are age related. Behaviour which is normal at 3 years of age is evidence of mental retardation in a 10 year old.

B3. A widely accepted classification system that combines IQ score with adaptive behaviour assessment has been developed by the American Association of Mental Deficiency.[1] It divides mental retardation into four levels: mild, moderate, severe and profound. The levels are evidenced by IQ's in the following ranges:

Level of Mental Retardation	*IQ Range for Level*
Mild	50-55 to approx. 70
Moderate	35-40 to 50-55
Severe	20-25 to 35-40
Profound	Below 20 or 25

But under this system IQ is not the sole determinant of classification. The level of mental retardation must also be evidenced by functioning at that level on the corresponding adaptive behaviour scale which relates behaviour to chronological age.[2]

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[1] H. Grossman ed., *Classification in Mental Retardation* (American Association on Mental Deficiency 1983) 13. Referred to as "AAMD".

[2] A similar system of describing functional levels is used by the Services for the Handicapped Division of Alberta Social Services for the purpose of determining the service requirements of mentally retarded persons. It ranges from Level I (persons living in the community and who are largely independent) to Level IV (totally dependent persons who exhibit disabilities in addition to severe or profound mental retardation). An older classification systems divides mental retardation into moron (IQ 50-70), imbecile (IQ 30-50), and idiot (IQ 0-30); another system, based on educability, has divisions for educable (IQ 50-75), trainable (IQ 25-49) and custodial or untrainable (IQ below 25): W. R. Hughes, "Definition, Diagnosis, Classification and Associated Problems in Mental Retardation", (spring 1975) *Law & Psychol. R.* 23.

B4. For classification as mentally retarded, the impairment must have been manifested during the developmental period, that is, sometime between conception and age 18 years.[3] (Where the manifestations occur later the proper medical term is "dementia".[4]

B5. Normal development is reflected in the following sequence of progress:[5]

1. *infancy and early childhood*: the development of sensorimotor skills, communication skills (including speech and language), self-help skills and socialization (ability to interact with others);
2. *childhood and early adolescence* (a period of complex learning processes): the application of basic academic skills in daily life activities, the application of appropriate reasoning and judgment in mastery of the environment and the development of social skills (participation in group activities and interpersonal relationships);
3. *late adolescence and adult life*: the acquisition of vocational and social responsibilities "assessed in terms of the degree to which individuals are able to maintain themselves independently in the community and in gainful employment as well as by their ability to meet and conform to community standards".

Delays in the acquisition of these skills and abilities represent "deficiencies in adaptive behaviour and become the criteria for mental retardation".[6]

B6. An individual "may meet the criteria of mental retardation at one time in life and not at some other time".[7] For example, an unknown percentage of persons classified as mentally retarded at ages 10 to 14 (representing "the period of schooling when higher level mental functions and more complicated abstract thought processes are required for learning") are assimilated into the general population in adulthood (where the "expectations and demands of the environment for the kinds of intellectual skills needed to master school work" are reduced).[8] Most of them will have been classified as mildly retarded. (Another explanation for the disappearance of these persons from identifiable view in the population is that their adaptive capacities have improved with age and maturity.)

B. CAUSES OF MENTAL RETARDATION

B7. Mentally retarded persons fall into two main groups: first, biologically damaged persons ("clinical types" comprising about 25% of the mentally retarded population); and, second, psychosocially disadvantaged persons (the remaining 75% majority).[9] The groups are not mutually exclusive (there is some overlap between them); but they are conceptually useful.

B8. The biological damage to persons in the first group may have been caused by[10]

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[3] AAMD, *supra* n. 1 at 11.

[4] *Id*. at 12.

[5] *Id*. at 25-6.

[6] *Id*. at 26.

[7] *Id*. at 26.

[8] *Id*. at 76.

[9] *Id*. at 12-13.

[10] *Id*. at 59.

> ...genetic and chromosomal disorders, infectious processes, toxins and chemical agents, nutrition and errors of metabolism, gestational disorders, complications of pregnancy and delivery, and gross brain disease, many of undetermined origin. They occur in families in all strata of society.

Accidents during childhood are another source.[11]

B9. Persons in the first group "...are, as a rule, more severely disabled, have associated physical handicaps, and are heavily dependent on adults in their environment for support or survival".[12] They tend, in general, to be classified as severely or profoundly retarded, or perhaps as moderately retarded. They are the persons for whom contraceptive or hygienic sterilization is most likely to be sought.

B10. The causes of psychosocial damage are less apparent. Unlike biological damage, psychosocial damage is seldom attributable to a single cause. It is probable that genetic factors play a part in some cases. Clinically unidentifiable physical factors (e.g. children delivered prematurely or with low birth weight born to teenaged mothers, under- or malnourished women, or women who received inadequate care during pregnancy and delivery) may play a part in other cases. The quality of living experiences (e.g. the nature of family relationships and parental capacities for attention, affection and mental stimulation) is also a factor.[13]

B11. Persons in the second group "appear to be neurologically intact, have no readily detectable physical signs or clinical laboratory evidence[14] related to retardation, function in the mildly retarded range of intelligence, and are heavily concentrated in the lowest socioeconomic segments of society".[15] In some cases, the retardation may be manifested in regression from previously normal states.

B12. In general, these are the persons often identified as retarded only during the school years when society's intellectual expectations and demands of them are greatest. Many of them are assimilated into the general population as adults. Their functioning that does not depend on the use of intelligence appears to be normal. Most will be classified as mildly retarded; some may be classified as moderately retarded.

B13. Although the relative importance of the genetic and environmental factors identified above "cannot be fully substantiated at this point in time ...there is little doubt that innate potential and a stimulating environment are *completely necessary* determinants of intellectual growth".[16]

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[11] *Id*. at 66.

[12] *Id*. at 59.

[13] *Id*. at 71-2.

[14] *I.e*. biomedical sign or symptom.

[15] AAMD, *supra* n. 1 at 13.

[16] *Id*. at 72.

APPENDIX C

ALBERTA SEXUAL STERILIZATION ACT[1]

C1. In its original form, the Alberta Sexual Sterilization Act established a "eugenics board" and provided for the sterilization of a person about to be discharged from a mental hospital where the board was of the opinion[2]

> ... that the person might safely be discharged if the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated.

The Act required the consent of the "inmate" if that person was capable of giving consent. Otherwise the consent of the spouse, a parent or guardian, or the Minister was required.

C2. The basic provision quoted above was amended in 1937.[3] The amendment had three significant features:

(1) psychotic persons and mentally defective persons were specifically mentioned for the first time;

(2) the criterion for sterilization in both these categories was no longer *solely* genetic - the risk of mental injury to the patient or progeny was made a ground for sterilization, just as was the risk of transmission of mental disease or disability;

(3) the consent of the person to be sterilized or of the spouse, a parent or guardian, or the Minister continued to be needed in the case of psychotic persons but the need for consent in the case of mentally defective persons was removed.

C3. A further amendment in 1942[4] specifically provided for sterilization of persons with neurosyphilis, certain epilepsies and Huntington's chorea. The patient's consent was needed except in the case of a patient with Huntington's chorea who was also psychotic.

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[1] First enacted S.A. 1928 c. 37; repealed S.A. 1972 c. 87.

[2] S.A. 1928, c. 37, s. 5.

[3] S.A. 1937, c. 47.

[4] S.A. 1942, c. 48, s. 3.

APPENDIX D

BIRTH CONTROL ALTERNATIVES TO STERILIZATION

D1. The decision to undergo a sterilization to prevent birth involves the rejection of other available methods of birth control which may be seen to exist on a continuum of choice. We will therefore briefly describe the alternatives.

D2. "*Contraception*" is defined as the prevention of fertilization of the ovum (the female egg). "*Birth control*" is wider than contraception. It includes the use of drugs or mechanical devices that interfere with the reproductive processes by inhibiting the fertilized ovum from implanting itself in the uterus lining. Implantation normally occurs 6 to 7 days after fertilization or 7 to 8 days after ovulation.[1]

D3. Birth control also includes the more controversial alternative of "*abortion*", that is, the termination of a pregnancy after fertilization and implantation but before the fetus has become viable (capable of sustaining life on its own or with the assistance of appropriate life supports). This is usually taken to be prior to around 20 weeks of gestation.[2] We will discuss abortion (paras. D22 to D30) separately from other methods of birth control (paras. D4 to D21).

A. METHODS OF BIRTH CONTROL OTHER THAN ABORTION

D4. Some methods of birth control require active participation on the part of the persons having intercourse. The oldest contraceptive method available, coitus interruptus, requires sufficient motivation and self-control by the male partner to withdraw before ejaculation. Barrier methods such as the condom, diaphragm and cervical cap, and spermicides that act to physically obstruct the sperm from entering the vagina or uterus require application prior to intercourse. The rhythm method, the only contraceptive method currently sanctioned by the Roman Catholic Church, requires that the woman accurately predict the fertile period in the menstrual cycle and avoid sexual intercourse during that time.

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[1] It is not entirely clear under Canadian law when pregnancy begins. Is an intervention that prevents implantation correctly classified as a contraception or an abortion? The issue is relevant to the application of the therapeutic abortion provisions of the Canadian Criminal Code. See the discussion in B.M. Dickens, "Abortion: Definitions and Implications" (1981) 124 *Can. Med. Assoc. J.* 133. In New Zealand, legislation has established that pregnancy begins not with fertilization but with implantation: Contraception, Sterilization and Abortion Act, 1977, Stats. N.Z. 1977, No. 112. In England, the Department of Health and Social Services has held that post-coital contraception by estrogen administration or IUD insertion is legal as long as it occurs within 72 hours of sexual intercourse. Ian Kennedy, Reader in Law at Kings' College London, advised the Pregnancy Advisory Service that "the morning after pill and other methods of post-coital contraception are legal, provided they are used as an emergency measure ..." before a fertilized egg is implanted in the uterus: Germaine Greer, *Sex and Destiny* (Picador ed. 1984) 171-2.

[2] Provincial vital statistics legislation requires the registration of a still birth when the dead fetus is delivered after 20 weeks gestation or when the fetus weighs 500 grams or more. *See e.g.* Vital Statistics Act, R.S.A. 1980, c. V-4, s-s. 1(v) and s. 8.

D5. These methods tend to rank among those with higher rates of subsequent pregnancies for persons in the general population.[3] They are unsuitable for mentally incompetent persons who, by definition, do not understand the biological basis of fertilization and reproductive processes.

D6. The remaining possibilities are: intrauterine contraceptive devices (IUD's), oral hormonal contraceptives ("the pill"), injectable suppressive hormonal therapy, and postcoital "contraception" (i.e. "contraception" after sexual intercourse). We will discuss them in turn.

1. Intrauterine "Contraceptive" Devices (IUD's)

D7. The IUD appears to be the most satisfactory of the four methods.[4] The failure rates range from 0.4 to 3 pregnancies per 100 women-years.[5]

D8. Disadvantages are that there may be pain on insertion, cramps and bleeding for hours or days afterward and double the menstrual flow. Pelvic infections may develop. Spontaneous expulsions do occur, usually in the first few months, and the woman should check routinely for the tail of the IUD to ensure that the device is still in place.

D9. Intrauterine devices have been advocated with caution for mentally retarded women.[6] They have also been found more satisfactory than oral contraceptives and injectable hormonal suppressants (paras. D10 to D16) by parents responsible for the care and supervision of such women.[7]

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[3] *E.g.* 3.36 pregnancies per 100 women-years for condoms; 2.4 pregnancies per 100 women-years for diaphragms; and 0.3 to 8 pregnancies per 100 women-years for spermicides: M.J.K. Harper, *Birth Control Technologies* (1983).

[4] The IUD is inserted through the cervical canal into the endometrial cavity of the uterus. It does not influence ovarian function. The effect is probably to prevent implantation of the fertilized ovum in the uterus.

[5] The IUD had the best safety record of birth control methods compared in a 1975 study, followed by the pill and combined use of a condom and/or a diaphragm. No other method was safer and more effective: A.K. Jain, "Safety and effectiveness of intrauterine devices" (1975) 11 *Contraception* 243; C. Tietz, "Mortality with Contraception and Induced Abortions" (1969) 6 *Studies Fam. Planning* 45.

[6] A.K. Kreutner, "Sexuality, Fertility and the Problems of Menstruation in Mentally Retarded Adolescents" (1981) 28 *Pediatr. Clin. North Am.* 475-80.

[7] A. Chamberlain et al., "Issues in Fertility Control for Mentally Retarded Female Adolescents: I. Sexual Activity, Sexual Abuse and Contraception" (1984) 73 *Pediatrics* 445.

2. Oral Hormonal Contraceptives (the "pill")

D10. "The pill" combines synthetic steroids similar to the natural female sex hormones (the estrogens and progestins) to inhibit ovulation.[8] It provides a woman with a highly reliable form of birth control provided that she does not omit to take the prescribed pills. The rate of failure is less than 0.2 pregnancies per 100 women-years.[9]

D11. There are however significant physical risks, particularly with long-term use and in older women. One-such risk is the inducement or enhancement of clotting in arteries and veins.[10] The risk of death rises for women 30 years of age and over who smoke but it is lower than the risk posed by pregnancy and childbirth.[11] Women who use oral contraceptives for 5 or more years face a ten-fold greater risk of death from circulatory disease than do women who have never used combined oral contraceptives.[12]

D12. The pill also has a number of unpleasant side-effects associated with the estrogen component. It may predispose susceptible women to a number of disorders seen in pregnancy (e.g. hypertension, jaundice, obesity, mental depression, loss of or reduction in sexual desire and persistent absence of menses). It can cause a variety of other pregnancy-related symptoms: most commonly nausea, vomiting, headache, breast engorgement and tenderness, weight gain and "pregnancy mask" (pigmented patches of irregular shape and size on the skin, especially on the face).[13]

D13. The pill has the advantage of being independent of sexual intercourse. However its use by a mentally retarded female requires the assistance of an adult who is motivated to supervise its administration, a task that is deceptively difficult. It would be the preferable contraceptive method for a very limited group of mentally retarded women.[14]

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[8] Pills containing estrogen and progestin are taken each day for 20 or 21 days beginning on the fifth day of the menstrual cycle. Withdrawal bleeding occurs within 3 to 5 days after completion of the 20 or 21 day regimen. The routine is started again on the fifth day of the new cycle. A variation is provided by a package containing 28 pills in specific sequence such that the first 20 or 21 pills contain the steroids and the last 7 or 8 tablets are hormonally inert. One pill is taken each day and there is no 'on' or 'off' interval to be remembered.

[9] *Supra* n. 3.

[10] While rare, the conditions that may result can be serious. The risk of deep vein cell death, cerebral cell death and obstruction of the cardiac or pulmonary arteries has been estimated to occur 3 to 6 times more frequently in women who used oral contraceptives than in non-users: *William's Obstetrics*.

[11] C. Tietze, (1977) 9 *Fam. Planning Perspect* 74.

[12] Population Reports, OC's - Update on Usage, Safety, and Side Effects. Jan. 1979, p. A-133.

[13] There is clinical experience with a "mini-pill" made up of a small daily dose of progestin alone that protects against pregnancy without suppressing ovulation. An advantage is that the side effects of estrogen are eliminated. Another is that no special sequence of pill-taking is necessary. However the pregnancy rate is higher (2 to 7 pregnancies per 100 women-years).

[14] *Supra* n. 7.

3. Injectable Hormonal Contraceptives (Depo-Provera)

D14. Steroid sex hormones may be injected intramuscularly to provide a woman with contraception for a month, 6 months or even a year.[15] A pure progestin may be used or a combination of a progestin with an estrogen. The compound most widely used is Depo-Provera. The contraceptive effectiveness is very high, comparing favourable to the combined oral contraceptives.

D15. The risks include those associated with the "pill", but once the drug is injected side effects such as depression, weight gain, nausea, dizziness and nervousness can last for months. There are also unresolved questions about its potential as a carcinogen (cancer-producing substance).[16]

D16. Injectable hormonal contraceptives have been found to be effective for mentally retarded adolescents who had been unable to comply with other contraceptive regimens. For this population the benefits may outweigh the known and potential risks.[17]

4. Postcoital "Contraception"

D17. We will discuss two methods of postcoital "contraception". The first is the "morning after" pill; the second is the IUD.

D18. There is actually no "morning after" pill as such. Large doses of non-steroidal estrogen (*e.g.* diethylstilbestrol, known as "DES") taken for five days begun within 3 days after an isolated exposure to unprotected intercourse have been found to be effective in preventing pregnancy.[18] Failure rates range from 0 to 2.4 pregnancies per 100 women-years.

D19. There is a potential carcinogenic effect in later life to female progeny who were exposed as fetuses. The use of estrogens as a "morning after" contraceptive is therefore not advisable unless an existing early pregnancy can be ruled out or induced abortion (paras. D22 to D30) is available as a back-up measure.

D20. IUD's have also been shown to provide effective postcoital contraception when inserted up to 7 days after unprotected intercourse. There is a risk that the IUD will induce abortion of an existing unrecognized pregnancy.[19]

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[15] Methods of male suppressive hormonal therapy are being experimented with but are not yet clinically employed.

[16] The U.S. Food and Drug Administration has not approved the use of Depo-Provera as a contraceptive for this reason and because alternative methods meet the needs of most users. The method is not recommended for widespread use by the Food and Drug Directorate in Canada but it is not prohibited for use and is used in select circumstances in Alberta.

[17] A. Chamberlain et al., "Committee on Drugs of the American Academy of Pediatrics (Medroxyprogesterone Acetate (Depo-Provera))" (1980) 65 *Pediatrics* 648.

[18] L.K. Kuchera, "Post-coital Contraception with Diethylstilbestrol" (1971) 218 *J. Amer. Med. Assoc*. The use of high doses of estrogen will protect against pregnancy provided the estrogen is given coincident to the transport of the egg through the uterine tube or long enough before ovulation to effect suppression of ovulation.

[19] J. Lippes et al., "Post-coital copper IUD's" (1979) 14 *Adv. Planned Parenthood* 87.

D21. Postcoital methods depend on rapid reporting and treatment. They will therefore be inappropriate for many mentally incompetent persons. However, where the risk of exposure to sexual intercourse is low and intercourse would likely be reported, postcoital methods may be preferable to preventive contraception.[20]

B. ABORTION

D22. We have defined abortion to mean the termination of a pregnancy after implantation but before the fetus has attained viability (para. D3). "*Induced abortion*" is the deliberate initiation of termination, usually in a manner designed to ensure that the embryo or fetus will not survive. All other abortions are "*spontaneous abortions*". They are commonly called miscarriages.

1. Abortion techniques

D23. The single most important determinant for the choice of method to induce abortion is the gestational stage of the pregnancy. There are one-stage and two-stage techniques. One-stage methods are usually used for termination in the first trimester. In one-stage techniques (vacuum aspiration,[21] classic dilation and curettage,[22] or hysterotomy)[23] the contents of the uterus are expelled in one intervention, usually instrumental. Abortions in very early pregnancy may be performed without any anaesthetic (except possibly for sedation). Later, local anaesthetic is usually preferred.

D24. Two-stage techniques, practically, are confined to the second trimester. The initial intervention is usually in the form of an intrauterine injection or infusion ("amniotic instillation") intended to induce contractions. These may last for varying lengths of time. No anaesthetic is used at this time because it may mask early symptoms or serious complications. The second stage involves the expulsion of the fetus and the placenta. Instrumental intervention is often required to complete the emptying of the uterus. Local, general or spinal anaesthetic may be used at this stage.[24]

D25. The risks of complication can be classified according to their time of onset as immediate, delayed and late. Immediate risks are hemorrhage and shock, perforation of the uterus, laceration of the cervix, incomplete abortion, and failure of two-stage abortion. Delayed risks are post-abortion bleeding, infection, inflammation and blood clotting in veins, and depression. Late or long-term complications include subsequent obstetrical problems (low birth weights, premature delivery and spontaneous abortion), Rh-immunization, and subsequent sterility because of hysterectomy, pelvic inflammatory disease or uterine adhesions.

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[20] The risk for mentally retarded women of exposure to sexual intercourse may be higher than generally recognized. A. Chamberlain et al., *supra* n. 7.

[21] Also known as suction curettage or uterine aspiration. After dilation of the cervix a metal or rigid plastic cannula is inserted in the uterus and the products of conception are dislodged from the uterine wall and removed by an electric pump connected to the cannula by a flexible tube. The average time required for the procedure is less than five minutes. Some gynaecologists complete the procedure with a surgical curettage (*infra* n. 22) to make sure no tissue remains.

[22] The procedure involves stretching the cervical canal by the insertion of a series of metal dilators, each one slightly larger than the preceding one. When the canal has been sufficiently enlarged to permit the passage of instruments into the uterine cavity, the contents of the uterus are removed with small forceps and then all remaining tissue is scraped out with a small metal curette.

[23] In essence, a caesarian section performed under general anaesthesia before the fetus is viable.

[24] W.H.O., "Task Force on Sequelae of Abortion. Gestation, Birth Weight and Spontaneous Abortion in Pregnancy after Induced Abortion" (1979) 1 *Lancet* 142-5.

D26. In countries that have had permissive abortion laws for a long period of time, the mortality rate is around 1.2 to 3.5 deaths per 100,000 abortions.[25] One of the main factors affecting mortality rate is the period of gestation at which abortion is conducted. In the U.S. 1972-80, mortality ranged from 0.4 per 100,000 abortions at 8 weeks or less to 14 per 100,000 for abortions at 21 weeks or more.[26] On the average mortality increased by almost 30 per cent each week of gestation. Nevertheless, mortality is significantly lower after first trimester abortion and even after early second trimester abortion than following childbirth at term. During 1972-78, mortality associated with childbirth was at least 7 times higher than mortality due to legal induced abortion (combining all gestational ages).[27]

D27. It is generally a criminal offence to induce an abortion ("procure a miscarriage") with intent. A person who does so may, however, be exempted from culpability under an exception to the general prohibition. The Criminal Code permits an accredited or approved hospital to establish a "therapeutic abortion committee" to decide that the continuation of the pregnancy would or would be likely to endanger the life or health of the mother and this determination must have been made for the abortion to be lawful.[28]

D28. The exception in the Criminal Code notwithstanding, abortion is a highly controversial issue in Canadian society at this time. Many persons ardently oppose it on religious and moral grounds.

2. Shortcomings

D29. Sharp regional disparities in the accessibility of abortion also make it an uncertain alternative to other methods of birth control.[29] The disparities are attributable to dramatic variances in the meanings attached to the word "therapeutic" by therapeutic abortion committees and in the prerequisite conditions imposed by committees.[30] A committee may well disregard the social, economic and other considerations that fall outside the scope of traditional medical treatment but are relevant to preventive contraception decisions. Since the establishment of committees is voluntary, not all hospitals nor even all localities have them.

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[25] *Id.*

[26] C. Tietze, *Induced Abortion: A World Review* (5th ed. 1983).

[27] S.A. LeBolt et al., "Mortality from abortion and childbirth: Are the populations comparable?" (1982) 248 *J. Amer. Med. Assoc.* 188-91.

[28] Criminal Code, R.S.C. 1970, c. C-34, s. 251(4)(c). Subsection 221(2) permits the life of an unborn child to be deliberately ended after labour begins but before the child has an existence outside the mother's body, when necessary to preserve the mother's life.

[29] *Report of the Committee on the Operation of the Abortion Law* (Robert F. Badgley, Chairman 1977).

D30. It is moreover clearly important, having regard to the woman's safety, to perform an abortion as early as possible and preferably not after the twelfth week of pregnancy. Therefore, as with postcoital contraception methods, reporting is important. If the mentally incompetent woman is unlikely to report sexual intercourse and subsequent signs of pregnancy, the evidence may come to light too late, especially since delays routinely attend therapeutic abortion committee procedures.

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[30] *Id.* at 29. The Report states:

> How danger to the health of a woman seeking an abortion was judged varied from the estimation that in no instance was this operation justified, a variety of intermediate interpretations, to the broadest possible definition which allowed an abortion to be done when it was requested by a woman. Based on these different understandings of the concept of health, a number of requirements were set for patients seeking this procedure and a wide range of guidelines were used in the review of applications for induced abortions. Hospitals with therapeutic abortion committees had on an average four requirements to be met by women prior to their application being reviewed (e.g. consent, length of gestation, residency or quota requirements, social service review). If equity means the quality of being equal or impartial, abortion committees across Canada were inequitable in their application and their consequences for induced abortion patients.

APPENDIX E

INCIDENCE OF STERILIZATION IN ALBERTA

TABLE 1

NUMBER OF MALE STERILIZATION PROCEDURES WHICH WERE PAID ON BEHALF OF ALBERTA RESIDENTS BY AGE GROUP DURING THE YEARS ENDED MARCH 31(1)(2)(3)

AGE GROUP	1981	1982	1983	1984	1985	1986
Under 1	-	-	-	-	-	-
1 - 4	-	-	-	-	-	-
5 - 9	-	-	-	-	-	-
10 - 14	3	1	1	-	-	-
15 - 19	3	2	2	2	1	-
20 - 24	148	140	120	163	127	147
25 - 29	740	703	743	932	917	1,129
30 - 34	972	921	1,123	1,410	1,487	2,004
35 - 39	465	431	621	794	916	1,315
40 - 44	201	173	206	310	318	472
45 - 49	99	75	73	112	102	152
50 - 54	38	37	35	45	41	50
Over 54	10	19	18	13	17	20
Unknown	-	-	271	-	-	-
TOTAL	2,679	2,502	3,213	3,781	3,926	5,289

NOTES:

1. Source: Alberta Health Care Insurance Plan (AHCIP) Claims File.

2. The data include fee-for-service items paid to medical practitioners in and outside Alberta, on behalf of Alberta insured residents, on a date-of-payment basis. The age of each patient is determined on the basis of the patient's AHCIP registration number as reported by the practitioner on his/her claim submission. Ages have not been verified for accuracy by the AHCIP.

3. Refers to sterilization by vasectomy.

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Health Economics & Statistics
Alberta Hospitals and Medical Care

TABLE 2

NUMBER OF FEMALE STERILIZATION PROCEDURES WHICH WERE PAID ON BEHALF OF ALBERTA RESIDENTS BY AGE GROUP DURING THE YEARS ENDED MARCH 31(1)(2)(3)

AGE GROUP	1981	1982	1983	1984	1985	1986
Under 1	-	-	-	-	-	-
1 - 4	-	-	-	-	-	-
5 - 9	1	-	-	-	-	-
10 - 14	3	5	5	3	1	3
15 - 19	34	37	52	43	41	43
20 - 24	1,063	1,087	972	1,098	1,001	1,233
25 - 29	2,697	2,911	2,844	3,141	2,809	3,348
30 - 34	2,695	2,999	2,878	3,193	2,907	3,573
35 - 39	1,240	1,408	1,552	1,825	1,638	2,046
40 - 44	453	457	437	439	403	533
45 - 49	92	113	84	85	66	88
50 - 54	11	7	3	8	3	5
Over 54	1	2	3	6	2	4
Unknown	-	-	683	-	-	-
TOTAL	8,290	9,026	9,513	9,841	8,871	10,876

NOTES:

1. Source: Alberta Health Care Insurance Plan (AHCIP) Claims File.

2. The data include fee-for-service items paid to medical practitioners in and outside Alberta, on behalf of Alberta insured residents, on a date-of-payment basis. The age of each patient is determined on the basis of the patient's AHCIP registration number as reported by the practitioner on his/her claim submission. Ages have not been verified for accuracy by the AHCIP.

3. Refers to sterilization by laparotomy, laparoscopy and colpotomy.

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TABLE 3

NUMBER OF HYSTERECTOMY PROCEDURES WHICH WERE PAID ON BEHALF OF ALBERTA RESIDENTS BY AGE GROUP DURING THE YEARS ENDED MARCH 31(1)(2)

AGE GROUP	1981	1982	1983	1984	1985	1986
Under 1	-	-	-	-	-	-
1 - 4	-	-	-	-	-	-
5 - 9	-	-	-	-	-	-
10 - 14	10	6	8	8	2	1
15 - 19	14	16	14	17	12	16
20 - 24	139	124	94	104	104	120
25 - 29	458	524	480	560	488	542
30 - 34	864	894	838	966	871	1,005
35 - 39	1,018	895	1,035	1,184	1,143	1,300
40 - 44	875	904	895	1,020	1,022	1,197
45 - 49	723	646	694	763	759	854
50 - 54	403	382	375	379	410	485
Over 54	569	550	520	677	618	775
Unknown	-	-	290	-	-	-
TOTAL	5,073	4,941	5,243	5,678	5,429	6,295

NOTES:

1. Source: Alberta Health Care Insurance Plan (AHCIP) Claims File.

2. The data include fee-for-service items paid to medical practitioners in and outside Alberta, on behalf of Alberta insured residents, on a date-of-payment basis. The age of each patient is determined on the basis of the patient's AHCIP registration number as reported by the practitioner on his/her claim submission. Ages have not been verified for accuracy by the AHCIP.

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TABLE 4

NUMBER OF STERILIZATION PROCEDURES PERFORMED FOR PERSONS UNDER AGE 18

For the Years Ended March 31

Age	Hysterectomy			Female* Sterilization			Male** Sterilization			Total		
	1976	1977	1978	1976	1977	1978	1976	1977	1978	1976	1977	1978
Under 1												
1 - 4												
5 - 9		1	1	1						1	1	1
10 - 14	18	20	11	1	1	2		1		19	22	13
15 - 17	8	12	7		3	3	1	5	1	9	20	11
TOTAL	26	33	19	2	4	5	1	6	1	29	43	25

* Sterilization by laparotomy, laparoscopy or colpotomy.

** Sterilization by vasectomy.

NOTE: The reasons reported for these procedures were:

(a) retardation
(b) birth defects

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APPENDIX F

GUARDIANSHIP OF CHILDREN - ALBERTA LEGISLATION

F1. There are two statutory sources of authority for the appointment of a guardian for a child in Alberta. One is Part 7 of the Domestic Relations Act - legislation that, for the most part, regulates relationships within the family.[1] The other is the Child Welfare Act.

A. DOMESTIC RELATIONS ACT

F2. On an application made to it under Part 7 of the Domestic Relations Act, the Court of Queen's Bench may appoint a guardian to act jointly with the father or mother of the child or with a guardian appointed by a deceased parent (a "testamentary guardian").[2] The court may also appoint a guardian for a child who has no parent or guardian, or whose parent or guardian "is not a fit and proper person" to be the child's guardian.[3] The effect of an order in the latter case is to terminate the guardianship of the person who is unfit. Unless otherwise limited, the guardian has "the custody of the child's person and the care of his education.[4] The guardian also has the authority to act for and on behalf of the child, appear on the child's behalf in court, and manage the child's estate. [5]

B. CHILD WELFARE ACT

(1) Children's Guardian

F3. Where a temporary or permanent guardianship order is made pursuant to a child welfare intervention for the protection of a child, guardianship authroity is conferred on a public official called the Children's Guardian. (See Appendix G.)

(2) Private Guardian

F4. An order of private guardianship may be made on application to the Provincial Court under Part 5 of the Child Welfare Act.[6] Part 5 applies irrespective of any child welfare intervention having occurred. To an extent, it duplicates the authority for the court appointment of a guardian under the Domestic Relations Act. However, its provisions, which are more detailed, differ in several respects. First, the applicant must have had continuous care of the child for more than 6 months.[7] (This requirement may be waived.)[8] Second, the Court must be satisfied that[9]

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[1] R.S.A. 1980, c. D-37.

[2] *Id.* at s. 49.

[3] *Id.* at s. 50.

[4] *Id.* at s-s. 46(d).

[5] *Id.* at ss-s. 46(a), (b) and (c).

[6] S.A. 1984, c. C-81. This is in addition to the guardianship that is placed with the Children's Guardian when an intervention is made under the Act.

[7] *Id.* at s-s. 49(1).

[8] *Id.* at s-s. 49(2).

[9] *Id.* at s. 53. An application cannot be made in respect of a child who is in care pursuant to a temporary guardianship order or during the appeal period following a permanent guardianship order: s-ss. 49(3) and (4). However, an application may be made in respect of a child who is in the permanent care of the Department of

(a) the applicant is able and willing to assume the responsibility of a guardian towards the child, and

(b) it is in the best interests of the child to make the order.

Third, the Court may terminate the guardianship of any other guardian, including a parent, if[10]

(a) the Court is satisfied that the other guardian of the child consents to the termination, or

(b) for reasons that appear to it to be sufficient, the Court considers it necessary or desirable to do so.

(3) Adoption

F5. Another source of guardianship authority, an order of adoption, is provided for in Part 6 of the new Child Welfare Act. An order of adoption may be made by a judge of the Court of Queen's Bench where[11]

(a) the applicant is capable of assuming and willing to assume the responsibility of a parent toward the child, and

(b) it is in the best interests of the child that the child be adopted by the applicant.

An adoption order places the adopted child and the adopting parent in the relationship of biological child and parent as if the child had been born to the adopting parent in lawful wedlock.[12]

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[9](cont'd) Social Services.

[10] *Id.* at s-s. 54(1). This could include a guardian appointed under the Domestic Relations Act, *supra* n. 1.

[11] *Id.* at s-s. 63(1).

[12] *Id.* at s-s. 64(1).

APPENDIX G

PROTECTION OF CHILDREN IN ALBERTA - THE CHILD WELFARE ACT

G1. Child welfare legislation has as its purpose the protection of children at risk in the family or community. Care is provided for children in cases where private arrangements are inadequate or abuses are occurring.

G2. In Alberta, a new Child Welfare Act took effect on July 1, 1985.[1] The Act spells out a number of principles to guide the court (in this case, the Provincial Court)[2] or any person acting under its provisions. It identifies the family as the basic unit of society. Support for and preservation of the family is to be fostered insofar as this is consistent with the recognition and protection of the interests of individual family members in general and children in particular: the family has "the right to the least invasion of its privacy and interference with its freedom that is compatible with its own interest, the interest of the individual family members and society".[3]

G3. An intervention may be made where a child is "in need of protective services" (i.e. there are "reasonable and probable grounds to believe that the survival, security or development of the child is endangered"),[4] but he should be removed from the family only if no less intrusive measure will adequately protect him.[5] Where it is necessary to remove the child, an effort should be made to respect the child's familial, cultural, social and religious heritage, and the benefit to the child of stability and continuity of care and relationships.[6]

G4. If an agreement that will safeguard the protection of the child's interests cannot be reached, other interventions are provided. That is to say, a court order of supervision, temporary or permanent guardianship may be sought.[7]

G5. A supervision order is the least intrusive order available to the court. It permits a child welfare director to supervise the care of the child at home.[8] The child's guardianship is unaffected.

G6. A temporary guardianship order may be made where it is necessary to remove the child from his family or community for the time being but the child's return is anticipated.[9] The order is not to exceed one year, with a total cumulative period of two years in most circumstances.[10] Under a temporary guardianship order, by order, a public official called the Children's Guardian[11] shares guardianship jointly with the child's parent or other guardian.[12] The Children's Guardian may, however, exercise the authority exclusively.[13]

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[1] S.A. 1984, c. C-8.1.

[2] *Id.* at s-s. 1(1)(g).

[3] *Id.* at s-s. 2(c).

[4] *Id.* at s-s. 1(2).

[5] *Id.* at s-s. 2(3)(ii).

[6] *Id.* at s-ss. 2(f) and (h).

[7] A person who is a guardian under an agreement or order under the Child Welfare Act is a guardian under the Domestic Relations Act, R.S.A. 1980, c. D-37, at s-s. 1(4).

[8] *Supra* n. 1 at s. 14.

[9] *Id.* at s. 15 and s-s. 29(1).

[10] *Id.* at s-s. 29(1) and s. 31.

G7. A permanent guardianship order is reserved for extreme cases. Under it, the child is permanently removed from his family and the Children's Guardian becomes, automatically, the child's sole guardian.[14]

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[11] *Id.* at s-s. 29(2). The Children's Guardian is appointed by the Minister of Social Services, being the Minister responsible for the Act: s-s. 94(2). Department literature describes the responsibilities of the Children's Guardian as follows:

- to safeguard the personal interests of the child while he is in protection;
- to decide or consent for the child;
- to monitor the custody decisions made by the directors (there are six child welfare directors appointed under the Act and responsible for the provision of protective services to children) and the care provided to ensure that the child's best interests are being served by the service providers; and
- to advocate on behalf of children in protection for the services required and seek modification of services or decisions that are not in a child's best interests.

The Children's Guardian is permitted to, and in practice does, delegate many of his guardianship duties and powers to other actors in the child welfare system: s-s. 87(3).

[12] *Id.* at s-s. 29(2).

[13] *Id.*

[14] *Id.* at s. 33.

APPENDIX H

EVOLUTION OF AMERICAN STERILIZATION LAWS

A. DECLINE OF EUGENIC STERILIZATION[1]

H1. Earlier in the century, various American states passed eugenic sterilization statutes. In the 1927 case of ***Buck*** v. ***Bell***, the United States Supreme Court upheld their constitutional validity.[2] The statute in that case provided several procedural safeguards for the person to be sterilized: a petition to a special board of directors of the institution in which the person resided; notice of the time and place of the hearing to the person, his guardian (with provision for application for the appointment of a guardian where none existed) and, in the case of a minor, his parents; presence of the person at the hearing; reduction of evidence to writing; appeal on the record and any other admissible evidence offered to the Circuit Court of the County; and appeal on the record of the trial in the Circuit Court to the Supreme Court of Appeals. It was argued that sterilization would be of benefit to the mentally disabled persons who "if incapable of procreating might be discharged with safety and become self-supporting with benefit to themselves and to society".[3] The decision in ***Buck*** v. ***Bell*** still stands.

H2. Eugenic sterilization has fallen into disfavour in more recent years. In the 1942 case of ***Skinner*** v. ***Oklahoma***, the United States Supreme Court ruled as unconstitutional an Oklahoma statute that provided for the eugenic sterilization of habitual criminals.[4] The Act denied the equal protection of the law because sterilization was permitted on the basis of legal distinctions between offences that were intrinsically of the same quality and no scientific connection was established between the offences for which sterilization was permitted and the biological inheritability of the relevant criminal traits. In addition, Skinner had not been afforded an adequate hearing. The hearing had been confined to the question whether sterilization would be detrimental to his health. He was not given a hearing on the question whether his criminal tendencies were of an inheritable type before he was "condemned to [the] irreparable injury"[5] of sterilization. The revulsion at the inhumane "experiments" in sterilization performed by the Nazi doctors which came to light after World War II helped the decline in acceptance of sterilization for eugenic reasons.

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[1] In this exposition the word "sterilization" is used to describe a sterilizing procedure undertaken for a purpose other than medical treatment.

[2] ***Buck*** v. ***Bell***, 274 U.S. 200.

[3] *Id.* at 206.

[4] ***Skinner*** v. ***Oklahoma***, 316 U.S. 535.

[5] *Id.* at 45 (*per* Chief Justice Stone).

B. EXISTING STERILIZATION STATUTES

H3. Several states still have sterilization statutes.[6] The statutes that do exist usually authorize the sterilization of persons confined in designated institutions.[7] However, the motives for supporting compulsory sterilization are changing. Emphasis is now being placed on the ability to parent and the fact that "one inevitably will find that certain [mentally disabled persons] will lack those social and emotional attributes which are generally considered desirable or, at the very least, necessary for child rearing".[8]

H4. An advantage of the sterilization statutes is that they usually set out procedural safeguards.[9] Statutes that permit interference with a basic human right must meet constitutionally guaranteed standards of due process.[10] Statutes that do not will be struck down as unconstitutional. Courts sometimes specify the procedural standards that must be met for statutory provisions to be upheld.[11]

H5. For compulsory sterilization of institutionalized persons due process requires "both a hearing on notice before a competent tribunal and an untrammeled right of appeal to the courts".[12]

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[6] Different writers report different numbers. Monroe E. Price and Robert A. Burt, "Sterilization, State Action, and the Concept of Consent in the Law and the Mentally Retarded" (1975) 1 *L. and Psych. Rev.* 57 at 61, writing in 1975, reported that 29 states had compulsory sterilization statutes. Ellen J. Barron, "A Parent's Right to Seek Sterilization for an Incompetent Minor" (1981) 16 *Forum* 1081 reported that 27 states had statutes authorizing the sterilization of mentally disabled persons (at 1082, n. 3). C. Struble, "Protection of the Mentally Retarded Individual's Right to Choose Sterilization: The Effect of the Clear and Convincing Evidence Standard" (1983) 12 *Capital U.L.R.* 413 at 418-20, cites a 1981 comment in 9 *Fla. St. U.L. Rev.* 599 at 639 for the statement that some states have declared that substituted consent by the parent or guardian is sufficient to authorize sterilization but (at 606-7, n. 23-25) that in addition to New Jersey, only nine states now have specific statutes on non-consensual sterilization and that since 1970 nine other states have repealed their sterilization statutes while one statute has been judicially overturned. A 1973 Alabama case, *Wyatt* v. *Aderholt* 368 F.Supp. 1383 (M.D. Ala. 1974) held that a state could not statutorily invest a guardian of a mentally disabled person living in an institution with the power to authorize sterilization for that person's benefit. The guardian could form the opinion that sterilization is desirable and initiate a review by a special tribunal but a court must make the eventual determination that sterilization is in the person's best interests. The effect is to put the burden on the state to justify any abridgment of a person's control of his own procreative activity.

[7] E.J. Barron, "A Parent's Right to Seek Sterilization for an Incompetent Minor" (1981) 16 *Forum* 1081 at 1082, n. 3.

[8] Price and Burt, *supra* n. 6 at 62.

[9] *See e.g.* the description of the notice and hearing provisions in the Virginia statute in issue in *Buck* v. *Bell*, *supra* n. 2.

[10] Fourteenth Amendment. U.S. Const. Amend. XIV s. 1.

[11] *E.g. Wyatt* v. *Aderholt*, *supra* n. 6.

[12] *In re Opinion of the Justices, No. 32* 162 So. 123 (1935), cited in M.W. Burns, "Wyatt v. Aderholt: Constitutional Standards for Statutory and Consensual Sterilization in State Mental Institutions" (Spring 1975) 1 *Law and Psych. Rev.* 79.

H6. Where interference with a basic human right is justified in the interests of society, the state must demonstrate that there is no less restrictive alternative which will achieve the same purpose. This principle, when applied, is useful because it "gives a clear picture of what is occurring, demands a recognition of the procedures that must be followed, and preserves a sharper record, in a sense, of the pattern of state intervention".[13] (We have referred to this principle in the main text of our *Report for Discussion* as a possible guide for making the choice between sterilization and other alternatives for birth control or menstrual management.)

H7. Statutes are the only source of jurisdiction to sterilize a mentally disabled person for the benefit of others and not himself.

C. CURRENT TREND

H8. In the United States, as in Canada, contemporary emphasis is being placed on integrating mentally disabled persons into the community ("communitization") and helping them to live normal and productive lives within the limits of their abilities ("normalization"). The sterilization statutes have tended to fall into disuse in part because of this contemporary trend. It has been said that "[s]tatistical data, though sparse, tends to suggest that the annual number of persons compulsorily sterilized ... declined by almost half" between 1955 and 1975".[14] The current availability of a wide range of alternative methods of birth control may also have contributed to the declining use of sterilization statutes.

H9. The sterilization statutes do not authorize the sterilization of mentally disabled persons who are not living in institutions.[15] It is not yet, however, generally agreed that all mentally disabled persons living in the community who are biologically capable of procreation should become parents.[16]

H10. The authority of parents and guardians to consent to surgery for minors and mentally incompetent adults in their charge is limited to therapeutic procedures: "the common law does not invest parents with [the power to authorize the non-therapeutic sterilization of] their children even though they sincerely believe the child's adulthood would benefit therefrom".[17] The common law authority of a parent to consent on behalf of a minor (and of a guardian to consent on behalf of a mentally incompetent adult) to surgical treatment is tied to the medical view of "benefit". It is an "authority of necessity" without which minors and mentally incompetent adults would be prevented, by operation of the principle of the inviolability of the person in the absence of personal consent, from obtaining medical treatment.[18]

H11. One reason for restricting the authority of parents and guardians to make sterilization decisions is the possibility of conflicting interests: "[d]iminished worry, convenience, a wish to be relieved of responsibility for close supervision, and inability to deal with a difficult problem may cause even the most well-intentioned parent or guardian to act against the retarded's best interest".[19]

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[13] *Supra* n. 8 at 66.

[14] *Id*. at 62-63.

[15] This has raised an equality rights issue for parents or guardians seeking the sterilization of non-institutionalized mentally incompetent persons: *Ruby* v. *Massey* 452 F.Supp. 361 at 367-69 (D. Conn. 1978); *In re Guardianship of Eberhardy*, 307 N.W. 2d 881 (Wisc. S.C. 1981).

[16] *Supra* n. 8 at 66.

[17] *A.L.* v. *G.R.H.* 325 N.E. 2d 501 at 502 (Ind. C.A. 1975); *see also Ruby* v. *Massey, supra* n. 15 at 366.

[18] See *Burns*, *supra* n. 12 at 89-91.

H12. Because their authority to consent is limited to therapeutic sterilization, parents and guardians have been turning to the courts for authority to proceed with non-therapeutic sterilization of the non-institutionalized minors and mentally incompetent adults for whose welfare they are responsible.

D. COURT JURISDICTION TO ORDER STERILIZATION

H13. There are three sources of court jurisdiction to hear applications for sterilization. The first is specific jurisdiction under statutes like the ones providing for sterilization of institutionalized persons. The second is general statutory jurisdiction such as that conferred on superior courts in Alberta by the Judicature Act.[20] This source is based on a broad interpretation of the inherent jurisdiction of courts in equity over mentally incompetent persons. The third is the *parens patriae* power. This is the power over minors and mentally disabled persons that was exercised historically in England by the courts on behalf of the King as the protector of his subjects. The second and third sources are close to the same because the *parens patriae* power was exercised by courts of equity and the statutes conferring general jurisdiction are codifications of the jurisdiction of the courts at common law and in equity.

H14. In their searches for sources of jurisdiction over sterilization, courts in some American states have found the jurisdiction in the second source: their general statutory jurisdiction. This source was recognized in the case of *Stump* v. *Sparkman*.[21] In that case, the United States Supreme Court found jurisdiction in an Indiana court because the broad general jurisdiction conferred by statute had not been circumscribed either by statute or case law so as to foreclose consideration of a petition for authorization of a minor's sterilization. It has been recognized in other decisions as well.[22] Courts in other states have found the jurisdiction in the third source: their *parens patriae* power.[23] Some courts have found that they have jurisdiction to hear sterilization applications but not to authorize non-therapeutic sterilization.[24] Courts in still other states have not found jurisdiction outside of the first source: specific statutory provisions.[25] Courts in those jurisdictions take the view that "[t]he legislature must assume the awesome power to deprive an individual of the right to procreate because sterilization is an extreme remedy which irreversibly denies a human being the fundamental right to bear or beget children".[26]

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[19] C. Struble, "Protection of the Mentally Retarded Individual's Right to Choose Sterilization: The Effect of the Clear and Convincing Evidence Standard" (1983) 12 Capital U.L.R. 413 at 418, citing *In re Guardianship of Hayes* 608 P.2d 635 (Wash. S.C. 1980) at 640 and *In re Guardianship of Eberhardy*, *supra* n. 15 at 897.

[20] R.S.A. 1980, c. J-1, ss. 5(1)(a), 5(3)(b) and 7.

[21] 435 U.S. 349 at 358 (1978).

[22] *E.g. In re Simpson*, 180 N.E. 2d 206 (Ohio Prob. 1962); *In re Guardianship of Hayes*, *supra* n. 19 at 637-9; *In re Moe*, 432 N.E. 2d 712 at 715-719 (1982); *In re A.W.* 637 P.2d 366 at 371-75 (1981); *Frazier* v. *Levi*, 440 S.W. 2d 393 (Tex. Civ. App. 1969); *Wade* v. *Bethesda Hospital*, 356 F. Supp. 380 (S.D. Ohio 1973).

[23] *E.g. In re Grady*, 426 A. 2d 467 at 479-81 (N.J.S.C. 1981); *Wentzel* v. *Montgomery General Hospital*, 477 A. 2d 1244 at 1253 (Md. C.A. 1982); *In re C.D.M.*, 627 P. 2d 607 at 609-12 (Alaska S.C. 1981); *Cf. In re Sellmaier*, 378 N.Y.S. 2d 989 (1976); *In Re Weberlist*, 360 N.Y.S. 2d 783 (1974); *Wyatt* v. *Aderholt*, *supra* n. 6.

[24] *E.g. Frazier* v. *Levi*, *supra* n. 22; *Wade* v. *Bethesday Hospital*, *supra* n. 22; *Hudson* v. *Hudson*, 373 So. 2d 310 at 312 (Ala. 1979); *In re Guardianship of Eberhardy*, *supra* n. 15 at 898.

H15. The outcome depends somewhat on whether the courts view sterilization as a burden or a benefit.[27] This, in turn, will depend on the circumstances of the individual case.

E. EVOLUTION OF THE CONSTITUTIONAL RIGHT OF PRIVACY

H16. The movement described above of mentally disabled persons out of institutions and into the community coincided with the delineation by the United States Supreme Court, in a succession of cases, of a constitutional right of privacy. The right of privacy constitutionally protects personal autonomy over decisions which are basic to the human enjoyment of life. That is to say, privacy means the right to self-determination.[28] Although it was originally found in the "penumbras" of specific guarantees in the constitution rather than in the words of any single section, as it has developed it has come to be associated primarily with the guarantees of liberty. Those are the guarantees that also protect against non-consensual violation of the person.

H17. The United States Supreme Court first began to speak of a right of privacy in 1965 in the case of *Griswold* v. *Connecticut* when it identified a right of "privacy surrounding the marriage relationship" and held that a state prohibition against the use of contraceptives was a violation of the fundamental right possessed by married couples to make decisions concerning procreation.[29] It had been established much earlier that the concept of liberty includes the right to "marry, establish a home and bring up children".[30] In *Griswold* v. *Connecticut*, the Court said that "specific guarantees in the Bill of Rights have penumbras, formed by emanation from those guarantees that help give them life and substance".[31] Specific guarantees contributing to the right of privacy were found in the Fourth, Eighth and Fourteenth Amendments that protect, respectively, against unreasonable searches and seizures, cruel and unusual punishments, and the undue deprivation of life, liberty or property and inequality.

H18. Under later decisions the right of marital privacy was molded into a broader right of personal privacy that protects choices relating to marriage, procreation, contraception and abortion. In 1969, privacy was stipulated to include "the right to satisfy [one's] intellectual and emotional needs in the privacy of [one's] own home".[32] In 1971, it was held to embrace the right of an individual, married or single, to determine whether to bear a child.[33] In 1972, it was held to be "broad enough to encompass a woman's decision whether or not to terminate her pregnancy".[34] In 1976, the right to seek an abortion without parental interference was extended to a "competent minor mature enough to have become pregnant".[35] In 1977, the state was foreclosed from imposing a blanket prohibition on the distribution of contraceptives to minors.[36] In 1979, the Supreme Court held unconstitutional a statute that required that parents always be consulted or notified before a minor could seek an abortion irrespective of the minor's maturity and competence to make her own decision.[37] In 1983, the Court invalidated a city ordinance that included a provision requiring hospitalization for all abortions performed after the first trimester of pregnancy.[38]

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[25] *E.g. Guardianship of Tulley*, 146 Cal. Rptr. 266 at 271 (1978).

[26] Struble, *supra* n. 19 at 420, citing *Guardianship of Tulley, id.*

[27] *Supra* n. 7 at 1088.

[28] M.T. Meulders-Klein, "The Right Over One's Own Body: Its Scope and Limits in Comparative Law" (1983) 6 *Boston College Int. Comparative L. Rev.* 29 at 78. In Europe, it means the right to "intimacy of private life."

[29] 381 U.S. 479 at 486.

[30] *Meyer* v. *Nebraska*, 262 U.S. 390 at 399 (1923).

[31] *Supra* n. 29 at 484.

[32] *Stanley* v. *Georgia*, 394 U.S. 557 at 565.

[33] *Eisenstadt* v. *Baird*, 405 U.S. 438.

H19. In all of these cases, the protection is of "an individual's ability to make fundamental decisions without excessive state interference".[39] The state may, nevertheless, assert its interest in important matters such as safeguarding health, maintaining medical standards and protecting potential life.

F. EXERCISE OF THE PRIVACY RIGHT BY MINORS AND MENTALLY INCOMPETENT ADULTS

H20. For mentally competent persons of any age, the constitutional guarantee of privacy protects the right to choose to procreate or not to procreate. The cases having to do with contraception and abortion make this clear.

H21. Constitutional principles of equality suggest that mentally incompetent persons, whether minor or adult, should not be denied the right of choice merely because they are unable to exercise it themselves. Over the last six years, there has been growing recognition that the courts that have held they lack jurisdiction over sterilization have effectively recognized only the right to procreate and foreclosed exercise of the right not to procreate. Instead of jurisdiction the concern of those courts should have been "whether or not an order sanctioning the sterilization of a particular incompetent would have been *constitutional*".[40]

H22. As we have pointed out, some courts have said that notwithstanding their theoretical jurisdictional base, sterilization is a matter for legislative policy and they will not act without it. They view sterilization as a burden, a serious violation of the person. Certainly, statutory authority is needed before sterilization may be ordered to meet other societal interests.[41]

H23. Other courts are trying to establish the principles and procedure by which the right of mentally incompetent persons to choose sterilization may be exercised. The right of parents and guardians to make decisions on behalf of a minor or mentally incompetent adult, it will be recalled, is limited to medical therapy partly because of the potential for conflicts of interest (paras. F10 and F11). There is no authority in parents or guardians to exercise the right to privacy.[42] If the authority to make sterilization decisions for a mentally incompetent person exists at all, therefore, it lies with the courts. Parents and guardians may assert the right of privacy for persons in their charge by initiating court proceedings.

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[34] *Roe* v. *Wade*, 410 U.S. 113 at 153-4.

[35] *Planned Parenthood* v. *Danforth*, 428 U.S. 52 at 74-5.

[36] *Carey* v. *Population Services*, 431 U.S. 678 at 694.

[37] *Bellotti* v. *Baird*, 47 U.S.L.W. 4969 at 4976.

[38] *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 103 S.Ct. 2481.

[39] Note, "The Minor's Right of Privacy: Limitations on State Action after Danforth and Carey" (1977) 77 *Colum. L. Rev.* 1216 at 1217.

[40] *In re C.D.M.*, *supra* n. 23 at 610; *see also In re Guardianship of Hayes*, *supra* n. 19 at 637.

[41] *Wentzel* v. *Montgomery General Hospital*, *supra* n. 23 at 1254, cited in Struble, *supra* n. 19 at 429: "in considering the best interest of the incompetent... the welfare of society or the convenience or peace of mind of the ward's parents or guardians plays no part".

H24. Courts that have assumed the authority to make sterilization decisions have proceeded cautiously in its exercise. They have applied one of two alternative tests. The first test involves the determination of whether sterilization is in the individual's "best interests". The second test involves making the decision the minor or mentally incompetent adult would have made in the circumstances if he had been competent to make the decision. It is called the exercise of "substituted judgment". The application of the best interests test is more usual.

1. Best Interests (including clear and convincing evidence standard)

H25. Under the best interests test, the authority to consent is approached not as a personification of the mentally incompetent person but as "a convergence of attitudes and policies held by society".[43] "Benefit" is defined by society rather than the individual.

H26. The courts administering the best interests test view the power over procreation as an "intensely personal right" and "take great care to ensure that the rights of mentally incompetent persons are jealously guarded".[44] The cases demonstrate their deep concern to protect mentally incompetent persons from the "physical and emotional consequences of the sterilization, and the irreversible, unalterable and permanent nature of the operation".[45]

H27. Some courts have imposed a "clear and convincing evidence" standard of proof that sterilization is in the best interests of the minor or mentally incompetent adult.[46] This standard of proof is higher than the normal civil standard of a preponderance of the evidence and is a burden usually imposed when the state seeks to interfere with individual rights. If the proponent of the sterilization does not meet the higher standard, the court will not authorize the sterilization. The effect is to raise a strong presumption that sterilization is not in the best interests of mentally disabled persons.[47] The higher standard of proof has been applied where the court recognized that the exercise by the court of its power is intended to compensate for a mentally incompetent person's inability to exercise her constitutional right of privacy over procreation.[48] Courts using it emphasize the principle of the inviolability of the person more than the principle of personal autonomy.[49]

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[42] *Ruby* v. *Massey, supra* n. 15 at 366.

[43] Burns, *supra* n. 12 at 95.

[44] *In re C.D.M, supra* n. 23.

[45] Struble, *supra* n. 19 at 428.

[46] *E.g. In re Guardianship of Hayes, supra* n. 19; *In re Grady, supra* n. 23; and *In re C.D.M., supra* n. 23. The standard may have to be applied independently to each issue, e.g. that the person is mentally incompetent to make a personal sterilization decision, the he or she has the capacity to reproduce, and that sterilization is the least restrictive alternative available for the purpose to be achieved (para. H6). An alternative view is that the person's best interests should be determined in the aggregate.

[47] Struble, *supra* n. 19 at 415. Of six courts recognizing jurisdiction in judgments reported in 1981 and 1982, five denied the sterilization and one set guidelines for lower courts making the decision.

H28. In assessing the mentally incompetent person's best interests, different courts have specified different factors to consider in their best interests tests. The factors include that the person:

1. is incompetent to understand reproduction or contraception and make a sterilization decision;
2. is unlikely to become competent;
3. is incompetent to make a sterilization decision (this is particularly important for minors and young adults);
4. is physically capable of reproduction;
5. is likely to be sexually active or exposed to sexual contact;
6. might experience physical or psychological trauma from pregnancy, childbirth or sterilization;
7. is incapable of caring for a child either alone or with a spouse.

Other factors are that:

1. less drastic methods of birth control are not feasible;
2. less intrusive sterilization procedures are not available;
3. sterilization is advisable at this time, contrasted to a future date;
4. scientific advances that will make less drastic contraceptive methods available or improve the person's condition are not foreseeable;
5. those requesting the operation are not seeking it for their own or the public's convenience;
6. sterilization is medically necessary to preserve the person's life or physical or mental health.[50]

2. Substituted Judgment

H29. The Massachusetts Supreme Judicial Court rejected the best interests test and requirement of clear and convincing evidence proof for sterilization decisions.[51] The fundamental issue, it said, was whether "the state [sought] to impose a solution on an incompetent based on external criteria, or ... to protect and implement the individual's personal rights and integrity".[52] The higher standard of proof was appropriate when the state interfered with a person's liberty, not when the individual sought to exercise his or her liberty.[53]

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[48] *In re Grady, supra* n. 23 at 481: "Consent by the court is a genuine choice nevertheless--one designed to further the same interests ... [the mentally incompetent person] might pursue had she the ability to decide herself. We believe that having the choice made in her behalf produces a more just and compassionate result than leaving ... [her] with no way of exercising a constitutional right."

[49] A 1981 decision of the Colorado Supreme court required the *medical necessity* of the sterilization to be proved by clear and convincing evidence: *In re A.W, supra* n. 22; *Wentzel* v. *Montgomery General Hospital, supra* n. 23 at 1254. *See also In re Guardianship of Hayes, supra* n. 19 at 643. Medical necessity is obviously a narrow approach to best interests.

[50] *In re Guardianship of Hayes, supra* n. 19 at 641; *In re Grady, supra* n. 23 at 482-3; *In re C.D.M., supra* n. 23 at 613; *Wentzel* v. *Montgomery General Hospital, supra* n. 23 at 1254.

[51] *In re Moe, supra* n. 22.

[52] *Id.* at 720.

[53] Struble, *supra* n. 19 at 435.

H30. The court decided that the substituted judgment test best promoted the interests of the individual. Substituted judgment is a test that had previously been applied to decisions concerning the cessation of mechanical or chemical life supports for terminally ill persons[54] and organ donations and transplants from mentally incompetent persons.[55] The court "'dons the mental mantle of the incompetent' and substitutes itself as nearly as possible for the individual in the decison-making process".[56] The Court heeds the wishes and values of the mentally incompetent person and decides as he would decide if he were competent. In this way his right of free choice and dignity as an individual are maintained.[57]

H31. The court is to exercise the utmost care in reviewing all the evidence presented. That is to say, the judicial proceeding must be thorough. It must consider, but not be concerned solely with, the following factors:

(1) whether the individual lacks the capacity to make a decision regarding sterilization;
(2) whether sterilization entails the least intrusive invasion of the incompetent;
(3) the medical necessity, if any, for sterilization;
(4) the nature and extent of the disability and whether the incompetent could care for a child;
(5) whether science is on the threshold of an advance in treatment of the disability;
(6) the likelihood of sexual activity;
(7) the possibility of health risks, or psychological damage; and
(8) the religious beliefs and special circumstances of the incompetent.[58]

H32. Where the mentally incompetent person's actual interests and preferences can be garnered from evidence of his experiences and expressions while competent or behaviour while incompetent, the substituted jugment test gives him as nearly as possible the same right to self-determination as a mentally competent person. It concurrently provides a forum for the assertion of the rights of the mentally incompetent person, satisfies the goal of equal protection of the right of procreative choice, and protects against parental or government abuses.

H33. On the other hand, it may be difficult to ascertain the actual desires and preferences of a severely mentally disabled person for sterilization, other means of contraception or parenthood,[59] especially if the condition has existed from birth or early childhood. It may also be difficult to avoid abuse of the mentally incompetent person: the test is not as predictable as that of clear and convincing evidence of best interests or medical necessity.[60]

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[54] *E.g. In re Quinlan*, 355 A. 2d 647 (N.J.S.C. 1976); *Superintendent of Belchertown State School* v. *Saikewicz*, 370 N.E. 2d 417 (1977).

[55] *E.g. Strunk* v. *Strunk* 445 S.W. 2d 145 at 147 (1969).

[56] *Superintendent of Belchertown State School* v. *Saikewicz*, *supra* n. 54 at 431, quoting *In re Carson* 39 Misc. 2d 544 at 545, 241 N.Y.S. 2d 288 at 289 (N.Y. Sup. Ct. 1962).

[57] *Id.*

[58] Struble, *supra* n. 19 at 438, citing *In re Moe, supra* n. 22 at 721-4.

[59] *In re Moe, supra* n. 22 at 720.

[60] *See* Struble, *supra* n. 19 at 435-38; L. Turner, "Mental Health Law - Proposed Legislation: Involuntary Sterilization of the Mentally Competent in Illinois" [1983] *S. Illinois U.L.J.* 227.

3. Procedural Safeguards

H34. The tests and factors described above provide personal (substantive law) safeguards for the rights of minors and mentally incompetent adults both from improper bodily violation and for the exercise of their right of privacy. The decisions also provide procedural safeguards.[61] These include: adequate notice (to the parties) of the proceedings; the appointment by the court of an independent guardian *ad litem* who would fully represent the interests of the mentally incompetent person at a full judicial hearing (the guardian *ad litem* should have full opportunity to present proof and cross-examine witnesses and ensure an adversarial proceeding so that both sides of each issue are presented) independent medical, psychological and social evaluations by competent professionals who may be appointed by the court; a personal interview by the court with the person for the purpose of forming an impression of competence; and right of appeal.[62]

H35. The sterilization decision is for the court: "It must be the court's judgment, and not just the parents' good faith decision, that substitutes for the incompetent's consent".[63] Parents or guardians may bring the sterilization proceedings on behalf of the minor or mentally incompetent adult and the court may authorize them to satisfy the procedural requirements of consent: "We do not mean that the trial judge must sign the consent form. Procedurally, the trial court should designate a guardian with authority to consent, as was done here. We only wish to point out the reality that the substance of the consent comes from the court rather than the guardian personally".[64]

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[61] Generally speaking, the terms "procedure" and "procedural law" describe the process followed by a person who has been wronged to obtain relief; the terms "substance" and "substantive law" describe the causes for which the law offers relief and the relief available, i.e. the rights and remedies.

[62] *Wentzel* v. *Montgomery General Hospital*, *supra* n. 23 at 1253-4; *In re Moe*, *supra* n. 22 at 721-4.

[63] *In re Grady*, *supra* n. 23 at 475.

[64] *Id.* at 475, n. 1.

APPENDIX I

LAW REFORM COMMISSION OF CANADA
WORKING PAPER 24
STERILIZATION: IMPLICATIONS FOR MENTALLY RETARDED AND MENTALLY ILL PERSONS
SUMMARY OF RECOMMENDATIONS

I1. The Law Reform Commission of Canada defined a therapeutic sterilization as[1]

> any procedure carried out for the purpose of ameliorating, remedying, or lessening the effect of disease, illness, disability, or disorder of the genito-urinary system.

It defined a non-therapeutic sterilization as[2]

> a safe and effective procedure resulting in sterilization when there is no disease, illness, disability, or disorder requiring treatment but the surgery is performed...for:
> (i) the control of menstruation for hygienic purposes;
> (ii) the prevention of pregnancy in a female; and,
> (iii) prevention of ability to impregnate by a male.

The operation for either a therapeutic or a non-therapeutic purpose could be undertaken with the fully-informed consent of a competent person voluntarily given. A sterilization for medical treatment could be performed on a mentally incompetent person with the consent of the next-of-kin or as an emergency if the next-of-kin is unable to give consent.[3]

I2. The Commission identified a need for the development of "objective, determinable standards"[4] for non-therapeutic sterilization of mentally disabled persons and recommended that two processes be implemented for this purpose: one for determining competence to give a valid consent "for the purpose of the criminal law"[5] and the other for making non-therapeutic sterilization decisions for mentally incompetent persons and persons younger than sixteen years.

I3. A competence hearing before a court would be initiated if the person's competence to consent were questioned, if the request for sterilization had emanated from a third party, or if there were any indication that a [person] requesting his or her own sterilization was "specially susceptible to coercion or undue influence to consent".[6] To be competent to give his own consent to a non-therapeutic sterilization the person would have to have the "ability to understand the nature and consequences of the particular medical procedure of sterilization".[7] The person would be represented at the hearing by an "independent advocate", that is, someone who is not the guardian or a relative or involved in the person's day-to-day care. An appeal would be provided.

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[1] Law Reform Commission of Canada, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24, 1979) 106.

[2] *Id.* at 107.

[3] *Id.* at 106-7. This would be in accordance with the broader general provisions contained in the Commission's Report No. 28: *Some Aspects of Medical Treatment and Criminal Law* (1986).

[4] *Supra* n. 1 at 107.

[5] *Id.* at 116.

[6] *Id.*

[7] *Id.* at 109.

14. Where competence is found, the physician performing a sterilization procedure would be able to rely on the person's own consent "according to usual practice".[8] (The Commission said earlier that "it should be the responsibility of the physicians involved in the sterilization procedure to ensure that the individual to be sterilized has understood the procedure and fully consented without undue influence".)[9] Where incompetence is found or the person is younger than sixteen years, a special tribunal would decide whether a proposed sterilization should be performed. The special tribunal would be a governmentally appointed "multi-disciplinary team of people qualified to evaluate the medical, social and psychological benefits" to the person and to decide whether there is a "compelling interest to justify the operation".[10] The recommendations do not define the meaning of "compelling" nor do they specify whose "interest". Later recommendations make it clear that only the interests of the person to be sterilized are to be considered. The Commission's reason for choosing a tribunal rather than the courts to make the decision was "to ensure that those persons most qualified to determine 'real' benefit be given the most appropriate opportunity and forum to determine the most beneficial action".[11] The procedure, it said, should "maximize informality without compromising fairness".[12] The person would again be represented by an independent advocate and there would be a full appeal to the courts.

15. The sterilization would be authorized where the physical or psychological damage to the person involved in childbearing or childrearing is shown to outweigh the physical and psychological damage to the person caused by the sterilization.[13] It would need to be shown that the person is of child-bearing age, sexually active and probably fertile, and that other forms of contraception have proved unworkable. Evidence of the person's wishes would also be necessary.

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[8] *Id.* at 110.

[9] *Id.* at 106.

[10] *Id.* at 112.

[11] *Id.*

[12] *Id.*

[13] *Id.* at 113.

APPENDIX J

1980 ONTARIO BILL: AN ACT RESPECTING CONSENT TO HEALTH CARE SERVICES SUMMARY OF RECOMMENDATIONS RELATING TO STERILIZATION

J1. The Ontario Bill does not use the word "sterilization" but speaks instead of "a surgical operation or medical procedure that will render or that is likely to render a person permanently incapable of natural insemination or of becoming pregnant".[1] The bill does not use the word "therapeutic" or "non-therapeutic". It would, however, require the approval of a special tribunal to perform a sterilization on a mentally incompetent person, minor or adult, unless it is "medically necessary for the protection of the [person's] physical health".[2] The substitute consent of the nearest relative (or other authorized person) is sufficient in the case of the exception for medical treatment.[3]

J2. The Bill embodies special protections for adults living in institutions, minors wherever resident,[4] and mentally incompetent adults living in the community.[5] Adults living in institutions and minors wherever resident could not be sterilized for a purpose other than medical necessity until their competence or incompetence to make a personal sterilization decision had been determined under a set procedure.[6] Mental competence would be defined as the ability "to understand and appreciate the nature and consequences" of the sterilizing procedure and "to understand and appreciate the consequences of giving or withholding the consent".[7] The process would be this:[8] the physician who is to perform the sterilization would be obliged to determine whether the minor or institutionalized adult is mentally competent to give a personal consent and serve a form containing his decision on the person involved, his nearest relative or the Public Trustee, and the Official Guardian, any of whom may apply to the court for a declaration as to the validity of the physician's decision. A 30-day waiting period would be allowed for application to be made. The Official Guardian, or with his consent someone else approved by the court,[9] would be the legal representative of the person to be sterilized and have the function of safeguarding his or her best interests.[10]

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[1] 1980 Ontario Bill, "An Act respecting Consent to Health Services", s. 15.

[2] *Id*. Note that this is narrower than the definition of "therapeutic sterilization" adopted by the Supreme Court of Canada in *Re Eve*. The Supreme Court definition encompasses sterilization in the person's best interests for the protection of physical or mental health.

[3] *Id*. at s. 12. The person giving the substitute consent must act in good faith and have regard to the best interests and wishes of the mentally incompetent person.

[4] *Id*. at s. 6. Minors sixteen years of age or more and adults would be presumed competent to make medical treatment decisions unless the physician "has reasonable cause to believe" that a person is not competent for this purpose: section 5. Minors under sixteen years of age would be presumed not to be mentally competent.

[5] We discuss mentally incompetent adults living in the community in para. J5.

[6] *Supra* n. 1 at s. 7 and s-s. 8(4).

[7] *Id*. at s. 3.

[8] *Id*. at s. 20.

[9] *Id*. at s. 31.

[10] *Id*.

J3. The approval of a special tribunal, after a hearing,[11] would be needed to perform a non-medically necessary sterilization on the minor or institutionalized adult, whether or not a court had determined competence. The special tribunal would include one or more lawyers, physicians, other persons with special knowledge, and persons who do not fall within these categories.[12] The physician would have the duty to initiate the hearing.[13]

J4. The basis for approval of the sterilization of a mentally incompetent person would be different than that recommended by the Law Reform Commission of Canada.[14] The tribunal would have to find that the person is or is likely to be permanently incapable of rearing children or of fulfilling the role of a parent.[15] Apparently, it is not the interests of the person involved which would prevail but rather the interests of the unborn children (or possibly those who would have to accept responsibility for them). The bill does not say whether or not financial considerations would enter into the decision. The factors which would have to be established are similar to those proposed by the Law Reform Commission of Canada. They would be: mental incompetence, both present and prospective; "reasonable certainty" of fertility; and the unavailability of less restrictive alternatives.[16] The Official Guardian (or someone else to whom he consents, this time approved by the special tribunal) would again be the legal representative of the person to be sterilized and have the function of safeguarding his or her best interests.[17] An appeal would lie to the High Court and then to the Court of Appeal.[18]

J5. The approval of the special tribunal would also be needed to perform a non-medically necessary sterilization on a mentally incompetent adult living in the community.[19] The provisions would be the same except that the physician would not have to serve his decision about competence on anyone and there would not, it appears, be any statutorily conferred jurisdiction on the court to rule on competence except by way of appeal from the tribunal.

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[11] *Id*. at ss. 23-26.

[12] *Id*. at s. 21.

[13] *Id*. at s. 23.

[14] See Appendix G.

[15] *Supra* n. 1 at s. 19.

[16] *Id*.

[17] *Id*. at s. 31.

[18] *Id*. at ss. 27-29.

[19] *Id*. at s. 22.